SEPTEMBER • OCTOBER 1964

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Use of Drugs in Child Psychiatry

A River Trip for Delinquent Boys

Helping Neighbors Work Together

Case Report—A Child and Surgery

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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ALONE AND TROUBLED, this child seems to sense the social isolation which so often aggravates the problems of mentally retarded children. Helping the mentally retarded child and his parents to break through such isolation and make the most of his potentials challenges the skill of a variety of professions. How work with the mentally retarded can transform the abstract concepts of social work into vivid realities for social work students is described in the article beginning on page 189.

A pediatrician as well as a psychiatrist, **Dr. Leon Eisenberg,** has been on the staff of Johns Hopkins Hospital since 1954, and has held his university professorship since 1961. He is a member of the U.S. National Committee on Vital and Health Statistics, editor of the *American Journal of Orthopsychiatry,* and editorial board member of other psychiatric journals. From 1958 to 1964 he was consultant to Baltimore City Hospital.

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# ROLE OF DRUGS IN TREATING DISTURBED CHILDREN

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FEW TOPICS of discussion generate more heat and less light than the proper role of drugs in treating disturbed children. At one extreme are those physicians who argue that meaningful treatment is possible only by using the insights provided by psychotherapy—that drugs, if they function as more than placebos, do so only as chemical strait jackets for troublesome children—and that their use serves to delay recognition of the real psychopathology in the family. At the other extreme are those physicians who consider drugs *the* agents of choice because drugs attack disturbed function at the physiologic level, the place at which they believe the ultimate pathology lies. Partisans of this viewpoint usually also deride psychotherapy as an insubstantial metaphysical occupation, hardly worthy of the honorable calling of a physician. The controversy engages the passions of psychologists, social workers, and teachers, as well as parents. The first law of psychopharmacology might be formulated to state: the certainty with which convictions are held tends to vary inversely with the depth of the knowledge on which they are based.

There is as yet no universal and completely validated theory of human behavior that would permit a confident prediction of the utility of drugs. Even if we had such a theory the final decision would remain an empirical one. If an agent works well, then a physician, whatever his theoretical persuasion, will be a fool not to use it. For an empiricist, the relevant question becomes: What are the facts?

The work reported in this paper was supported in part by a grant (MY–2583) from the National Institute of Mental Health.

### *Experimental Principles*

First, it is necessary to consider how the "facts" are obtained. If we wish to know whether aspirin lowers fever we need first of all accurate thermometers to measure fever. Then, we need a group of febrile patients to study. Next, since we know that fever is usually a transitory rather than a permanent condition, we need an experimental design that permits us to discriminate between a drug effect and a "natural" return of the patient's temperature to normal levels. This might be accomplished by having matched groups of patients, one treated by aspirin and one untreated, or perhaps one treated by aspirin and one treated by a second drug. But hold! What does the word "matched" mean in this context?

We know before we start the experiment that the fevers of a cold, of pneumonia, or malignancy, and of brain injury differ from one another in their mechanisms, duration, and susceptibility to modification. Furthermore, the course of the same disease differs in young and older patients; also, if other treatments are administered, these may influence the course of the fever.

Thus, a proper experimental design will require that the control and experimental patient groups be equivalent on those variables known to influence the phenomenon under study: in this case, the variables include diagnosis, age, other treatments, and

other factors such as severity of condition and duration of illness. Moreover, we have to assume that other variables not known at the time of the study may be important. Since we cannot match patients on unknown factors, we attempt to take this into account by the random assignment of patients to one or the other group.

With these elementary conditions fulfilled, we must now include a sufficiently large and representative sample of patients to permit the meaning of any obtained differences between groups to be subjected to statistical analyses. These are simply mathematical procedures that enable us to determine how often the observed difference might be likely to arise by chance alone.

Again, the word "representative" requires attention. If we are to have any confidence that our treatment is useful for certain diseases, then we need to be reasonably sure that our sample is representative of patients with the diseases under study. For example, if they were all adults, we would not know whether the findings would hold true for children—indeed, for aspirin we would get quite different results.

Perhaps this simple model will illustrate the ingredients of a well-planned drug study: specification of the phenomenon to be studied; accurate instruments to measure the phenomenon; control for subject variables likely to influence outcome; random assignment to treatment groups; numbers sufficient to permit statistical analysis of findings; and a representative study population.

### *Effects of Expectation*

But we have thus far not considered a major element in drug studies particularly relevant in psychopharmacology—the psychological effect of administering medication upon both the patient and the physician. We have all had the experience, when ill, of beginning to feel better once the doctor arrived, even before treatment began. Countless studies have demonstrated, both with objective signs (blood pressure, heart rate, skin lesions, and so forth) as well as with subjective symptoms (depression, anxiety, pain), that the *expectation* of a beneficial effect is often in itself sufficient to cause striking improvement.

When the medication is given to a child, it may influence him psychologically in one of two ways or both: (1) directly through his own expectations; (2) indirectly through altered parental behavior generated by anticipation of change in the child. Also, the physician or technician who judges the response may read into it results in keeping with the expected outcome. This is not "cheating"; the bias is usually outside the observer's awareness. Consequently, special precautions are necessary to keep from the patient *and* the doctor knowledge of the medication the patient is taking. This is done by giving a placebo, an inert substance made to resemble closely the active drug. The record of which patient is getting the drug and which the placebo is kept coded and is not revealed until all results have been scored. Such an experiment is termed "double blind."

### *Problems in Psychopharmacology*

Evaluating the published data from drug studies in children is a complex task.[1] Consider first the question of the accuracy of the instruments for measuring the behavioral aberrations of our patients. In lieu of a "psychiatric thermometer" with known validity (correspondence of readings with actual temperature) and reliability (margin of error for repeated readings by different observers), we are restricted to such techniques as: evaluating mothers' reports of symptoms, observing the child, getting information from schoolteachers, using psychological test data, and fitting the data patterns into clinical judgments.

Changes in the mother's report may reflect actual changes in the child's behavior *or* changes in her perception of the same behavior; we cannot easily distinguish between the two. Observations of the child in the clinic may be limited in usefulness by the fact that children often behave atypically during the clinic interview. Teachers' reports, though valuable, are nonetheless subject to limitations. The child may not exhibit the target symptom in the classroom; the teacher's judgments are likely to include elements different from the clinician's; the teacher is herself vulnerable to "halo effects" because she knows the child is receiving help. Many standard psychological tests have not been designed to be sensitive to change over short periods. Somehow the clinician must combine these disparate elements into an overall judgment that he hopes will be a valid appraisal of the child's condition at the end of the trial. One can, with proper precautions, come to reasonable conclusions. At the least, however, pronouncements of finality do not seem warranted.

Our difficulties are no less severe when we come to controlling relevant variables. We can, of course, specify age, sex, and social class—all likely to influence outcome. But when we turn to so crucial an

**Table I**

**TREATMENT RESULTS**

| Treatment | Improvement Rating | | | Total |
|---|---|---|---|---|
| | Marked | Mild | None | |
| Placebo | 14 | 5 | 6 | 25 |
| Meprobamate | 9 | 10 | 5 | 24 |
| Prochlorperazine | 7 | 11 | 10 | 28 |
| Totals | 30 | 26 | 21 | 77 |

item as diagnosis, we are in trouble. No completely acceptable system is available for classifying children's psychiatric disorders. Some investigators try to bypass this problem by focusing on symptoms, selecting patients at random, and hoping that chance will have placed equivalent patients in the several treatment groups. When one considers how different schizophrenias, phobic neuroses, personality disorders, and adjustment reactions are in severity and prognosis, this would seem an idle hope. Diagnostic heterogeneity increases the likelihood of what statisticians term a "type II error": falsely concluding that no difference exists between treated and untreated groups. Many of the psychopharmacologic studies reported in the literature either give no indication of the disorder treated or lump together highly disparate conditions.

The remaining requirements can be met: random assignment, numbers large enough for statistical analysis, representative study population, and double-blind design. The fact that they are often *not* met reflects on the investigators rather than on the inherent limitations of current knowledge. It is dismaying that so many clinical reports state that a given drug is "highly effective" in the treatment of behavior disorders because of a 50- or even 70-percent improvement rate when no placebo group was included. The fact is that like improvement rates can be obtained from inert placebos because of (a) the physician's impact on the family; (b) the positive expectations aroused by treatment; and (c) physician bias in favor of improvement. Indeed, so strong is this physician and placebo effect in certain disorders that a drug would have to have rather extraordinary power to demonstrate conclusive superiority over the comparison placebo group. Useful drugs may be discarded because the requirements for showing effectiveness are so stringent. But, then, if a physician using an inert drug or his own personality can get good results, why expose the patient to possible toxicity and to the cost of new drugs?

These general considerations can best be illustrated by citing some problems encountered in studies at our clinic. In one study we assigned psychiatric outpatients randomly, on a double-blind design, to one of three treatment courses: meprobamate, prochlorperazine, both tranquilizers, and a placebo. All patients received concomitant brief psychotherapy. Although we did not match for age, IQ, sex, color, or social class, we did inspect our results to be sure that outcome had not been influenced significantly by disparity in these variables.

The children were rated at the end of the 7-week treatment period on the basis of mothers' reports, teachers' reports, and clinical observations. They were rated as markedly improved, mildly improved, or unimproved. A good correspondence between mothers' and teachers' estimates of improvement in the children gave us some confidence in the reliability of these evaluations, but we cannot be sure of their validity since we had no independent measures of behavior with which to compare them. The distributions of ratings for each treatment condition are shown in Table I. There is no evidence of benefit attributable to either of the active drugs—if anything, there is an appearance of superiority for the placebo.

The major finding of this study emerged in another direction.[2] Since there were no reliable differences attributable to type of treatment, we examined the improvement rates for each major diagnostic category, disregarding the specific treatment given. The outcome distributions are reported in Table II. The differences related to diagnosis are highly significant

**Table II**

**OUTCOME IN RELATION TO DIAGNOSIS**

| Diagnosis | Improvement Rating | | | Total |
|---|---|---|---|---|
| | Marked | Mild | None | |
| Neurotic | 15 | 6 | 0 | 21 |
| Hyperkinetic | 14 | 9 | 10 | 33 |
| Defective | 0 | 9 | 4 | 13 |
| Antisocial | 1 | 2 | 7 | 10 |
| Totals | 30 | 26 | 21 | 77 |

**Table III**

**OUTCOME IN RELATION TO DIAGNOSIS**

**(Three Studies Combined)**

| Diagnosis | Improvement Rating | | | Total |
|---|---|---|---|---|
| | Marked | Mild | None | |
| Neurotic | 48 | 17 | 6 | 71 |
| Hyperkinetic | 24 | 22 | 25 | 71 |
| Totals | 72 | 39 | 31 | 142 |

(probability of occurring by chance is less than 1 in 50). Diagnosis obviously has a major effect on clinical outcome. Had we ignored it and by chance assigned more neurotic children to either drug, the patient group on that drug would have enjoyed so good an outcome that we would have been led to regard that drug as a potent therapeutic agent.

Just how powerful and consistent these effects have been can be seen in Table III which summarizes the results of three outpatient studies (in none of which have tranquilizing drug effects been evident). The likelihood of this difference arising by chance alone is less than 1 in 1,000. Thus, these two categories of patients behave as if they were two distinct populations and must be dealt with quite differently. If we examine the improvement ratings for the neurotic children (54 percent showing marked and 91 percent at least mild improvement), it is evident that a drug will have to be remarkably effective to show a reliable superiority over placebo. This is why we have concentrated subsequent drug research on the hyperkinetic group whose treatment by placebo and brief psychotherapy is rather unsatisfactory.

A word of caution is necessary at this point. The studies thus far discussed have focused on *outpatients* (usually less seriously disturbed than children in residential treatment) and have included simultaneous, albeit brief, *psychotherapy*. Any generalizations from them must bear these essential factors in mind. Studies by others have shown that tranquilizers *can* be effective in the treatment of hospitalized children, at least in managing disturbed ward behavior. Possibly, in the treatment of neurotic outpatients tranquilizers might be useful in a situation where no attempt is made at psychotherapy. Review of the literature fails to reveal studies properly done to validate this possibility.

However, even if such evidence could be obtained, the reader should bear in mind that the psychotherapy included in our treatment schema consisted of five half-hour sessions, hardly an impractical amount for most settings in which children are treated. *All* drugs have toxic effects, some of which may not be evident until after long experience with them. Therefore, there would seem to be a strong argument for psychological management as the preferential treatment for neurotic disorders in pediatric outpatients.

Other studies at our clinic have focused on patient groups with a limited response to conventional treatment and have shifted to stimulant rather than tranquilizing drugs. A further experiment with a phenothiazine tranquilizer (perphenazine) on institutionalized delinquents once again demonstrated marked placebo effects (both by houseparent ratings of behavior and by improvement in the problem of bedwetting) but no detectable evidence of drug action other than unacceptable toxicity.[3] When we returned to the same institution for delinquents but employed dextroamphetamine, a stimulant, we obtained clear evidence of improved behavior in the adolescents on the drug.[4] The betterment was evident on two measures: symptom scores as rated independently by houseparents and by teachers, and sociograms, in which the patients rated each other. The verification of each measure by evidence of like effects on the other increases confidence in the results. Those on dextroamphetamine were significantly superior to those on placebo and to those in the control group. Placebo and control did not differ from one another.

This study, it must be pointed out, was limited to behavior in the institution. We would not anticipate maintenance of improvement once these delinquent youngsters returned to the same pathologic environment that spawned their behavior. The one toxic effect noted was weight loss (average 6 pounds) on the rather large dosages (40 milligrams per day) employed in the experiment. Clinical adjustment of dosage should enable the benefits to be obtained without such depression of appetite. Psychomotor excitement was not reported for any of the subjects, obviously an age-related result since excitement would be anticipated in adults. In a subsequent outpatient study, dextroamphetamine proved to be an effective drug in treating hyperkinetic children without producing excessive toxicity.

We have extended these studies to include a second stimulating drug, methylphenidate. Hyperkinetic

brain-damaged children, mostly retarded, were placed on a rotating treatment schedule in which they received methylphenidate, phenobarbital, and placebo by turns. The most striking result was a prompt deterioration of behavior in the children on phenobarbital; methylphenidate showed a significant superiority over placebo, though either was clearly better than phenobarbital. In a second study,[5] employing methylphenidate and placebo, we evaluated symptomatic response as well as psychological test performance in disturbed children in a residential treatment center. Once again, methylphenidate produced a statistically significant diminution in symptoms when contrasted with placebo.

In addition to measuring symptom scores, we examined the children's performance on Porteus Mazes which test both intelligence and impulsivity, for they require planning before drawing a pencil line through a labyrinth. The children were given individual IQ tests and then divided into three IQ ranges (low=65–79; mid=80–91; high=94–135). Half of the children in each IQ range were given methylphenidate, half placebo.

The results for the entire patient group demonstrate significant superiority of performance (less impulsivity) by those receiving methylphenidate. Examination of the three IQ ranges separately reveals that the effect is due to enhancement of performance among the children in the two lower IQ ranges. Among the youngsters of normal or superior test intelligence, no drug effects were obtained. Several learning measures were also employed in this study. There were suggestions of improvement in learning in the children on methylphenidate, but the results were equivocal.

### *Diagnostic Categories*

This brief excursion into problems of methodology indicates that the "facts" so cavalierly called for at the outset of this article are not so readily obtained, nor so completely reliable as we might wish. Yet drugs are being used in general medical practice to an extent that attests to the persuasiveness of advertising methods and to the weary search by physicians for a ready solution to the overwhelming burden of psychiatric disorders among their patients. Let us now consider what is known about the usefulness of drugs in relation to diagnosis and type of drug, and then propose general principles of treatment.

Children with ***psychotic disorders*** do not respond as dramatically to the currently available drugs as adult patients may. Nonetheless, the phenothiazine tranquilizers can be quite useful in checking destructive and impulsive behavior, thus rendering the child more accessible to educational and psychiatric management. Dosage must be adjusted on a highly individualized basis in order to obtain maximum benefit without a great penalty in impaired intellectual acuity. The more the psychotic symptom pattern resembles typical adult patterns, the more likely phenothiazines will reverse an acute psychotic episode.

***Neurotic disorders*** seem rarely to respond in decisive fashion to available medications, though drug trial may be justified when symptoms are overwhelming. Then, phenobarbital, because of low cost and limited toxicity, should be tried first. Diphenhydramine, an antihistamine, is a second drug worth exploration. Psychological management is the preferred modality of treatment.

The merits of drug therapy for ***personality disorders*** are uncertain. Stimulant drugs may have a role in treating aggressive and impulsive patterns. If anticonvulsants have a place, it is limited to cases with electroencephalographic abnormalities. Phenothiazines may be worth trying.

The basic intellectual limitation in ***mental deficiency*** as well as the underlying pathologic lesions in ***chronic brain syndromes*** are not modifiable by any known medications. But hyperkinesis and distractibility, the most disturbing symptoms in these patients, frequently can be relieved by stimulants such as dextroamphetamine or methylphenidate.[4–6] About 10 to 20 percent of these patients are unresponsive to stimulants or may actually deteriorate when they are used. For cases with focal EEG abnormalities, anticonvulsants are indicated; in the remaining cases, diphenhydramine or phenothiazines may be employed. Barbiturates are almost always contraindicated except for the control of an associated clinical epilepsy.

***Adjustment reactions*** rarely justify drug use, except for sedation in cases of acute anxiety following physical or emotional shock. These syndromes are related to environmental stress, and the physician should try to alter the family environment rather than drug the child, whose symptoms are a response to family pathology. Drugs may be more properly administered in treating the parents.

### *Classes of Drugs*

For our purposes, the drugs used to modify behavior may be classified into tranquilizers, stimulants, and antidepressants; the tranquilizers may be further

subdivided by potency and chemical structure. Mild tranquilizers and sedatives will be treated as a single class of drugs, in view of the lack of evidence that the mild tranquilizers produce less drowsiness or have greater effectiveness than the more traditional sedatives.[7]

**Major Tranquilizers.** The most potent tranquilizers are the ***phenothiazines,*** beginning with the familiar, extensively used, chlorpromazine. Phenothiazines can produce jaundice, extrapyramidal syndromes, and blood dyscrasias; they potentiate the effect of simultaneously administered barbiturates. When a phenothiazine is indicated in the treatment of a major psychiatric disturbance, the drug to be preferred with children is chlorpromazine because of its wider margin of safety for extrapyramidal manifestations. Prochlorperazine and perphenazine should be used quite cautiously with children because of the frequency of such alarming syndromes as painful torticollis (wryneck), trismus (lockjaw), and extrapyramidal seizures. ***Phenothiazines are powerful drugs and should be employed only when clearly indicated and with proper caution.***

The same strictures apply to ***reserpine*** and its derivatives, which have indications and limitations similar to the phenothiazines but, because of unpredictability, should be reserved for cases which have failed on phenothiazine.

**Mild Tranquilizers.** ***Diphenylmethane derivatives,*** such as hydroxyzine and diphenylhydramine, are mild tranquilizers. They have been used to treat behavior disorders, anxiety neuroses, and hyperkinetic syndromes.[8-10] Toxicity occurs less often than with the phenothiazines, but potency is also less.

***Propanediol derivatives,*** such as mephenesin and meprobamate, are of limited utility save as mild sedatives. Habituation and tolerance to these agents have been reported in adults, but not in the doses used with children; acute toxicity has resulted from accidental ingestion of large amounts. There is as yet insufficient evidence to delineate the role of such new agents as chlordiazepoxide and diazbepam in treating children despite the enthusiastic claims accompanying early clinical trials. Both these drugs, as well as meprobamate, are described as having muscle relaxing properties useful in treating cerebral palsy and allied disorders. They may give rise to drowsiness, rashes, and withdrawal effects.

**Sedatives.** Sedatives, drugs that allay anxiety and excitement, have long been available to physicians. Most widely used are the ***barbiturates.*** Sedatives have proved of limited value in treating the psychoses and were largely supplanted by tranquilizers once the antipsychotic potency of phenothiazines and rauwolfa derivatives were recognized. Unfortunately, many physicians have assumed, despite the lack of evidence, a similar high index of effectiveness for tranquilizers in treating neurotic disorders. Comparative outpatient studies indicate similar results with drugs classified as tranquilizers and those termed sedatives. Phenobarbital, because of its inexpensiveness, low toxicity, and relative safety, is preferred for psychoneuroses to the more exotic tranquilizers.

**Stimulants.** Stimulants, such as ***dextroamphetamine*** and ***methylphenidate,*** have their greatest usefulness in the treatment of the overactive and distractible child. Toxicity, manifested chiefly by anorexia and insomnia, can usually be controlled by modification of dosage. Prolonged medication with these drugs can apparently be maintained without serious hazard, though it is well to discontinue treatment during the summer when the child's symptoms are less disruptive to organized activity. There is risk of addiction in adolescents who get a "kick" from them. Uncontrolled use may result in toxic psychoses.

**Antidepressants.** Antidepressants have little use in child psychiatry. Claims for ***imipramine*** in the treatment of enuresis were not borne out in a recent study. A study with iproniazid in autistic children was abandoned after the acute liver toxicity in adults was recognized.

## *Principles of Drug Treatment*

Our observations have led us to the following principles:

1. ***Drugs can be useful agents in managing pediatric psychiatric disorders when chosen appropriately and applied with discrimination.*** They can control symptoms not readily managed by other means and can facilitate psychotherapy by allaying symptoms that disrupt learning. If they are not the panaceas portrayed in advertisements, neither are they the poisons claimed by their foes.

2. ***Skill in using drugs requires knowledge of their pharmacologic properties and sensitivity to their psychologic significance.***[9, 10] Every drug study reveals the potency of placebo effects—benefits occurring from relationship with physician and from positive expectations of patients. These effects can be used to potentiate pharmacologic results by recognizing that the prescription of medication is an important

communication to the patient and his family; contrariwise, they can have a negative impact if the physician regards drugs solely as weapons to impose control or as measures of desperation.

3. ***No drug should be employed without firm indications for its use, without careful control of the patient, and without due precautions against toxicity.*** With any potent drug toxicity is inevitable; to justify its use the severity of the condition and the likelihood of benefit must outweigh the possible toxicity. Toxicity studies on adults cannot be safely extrapolated to children because of differences in the immature and developing organism; clinical decisions must be based on data from pediatric studies.

4. ***An old drug is to be preferred to a new drug unless evidence of superiority for the latter is clear.*** This principle of pharmacologic conservatism is based upon the fact that unexpected toxicity from a new agent may be apparent only after prolonged experience with it. This is not pharmacologic nihilism. Drugs can make a decisive difference in treatment, but their very potency commends us not to use them lightly.

5. ***Drugs should be used no longer than necessary.*** Dosage should be reduced periodically, with the goal of ending treatment if symptoms do not return on lower dosage.

6. ***Dosage must be individualized.*** Each person is metabolically unique. Undertreatment as well as overtreatment can result in erroneous conclusions about unsuitability of a particular medication for a particular patient.

7. ***The use of drugs does not relieve physician of responsibility for seeking to identify and eliminate the factors causing or aggravating the psychiatric disorder.*** *All* currently available psychopharmacologic agents treat symptoms not diseases. Symptomatic relief is not to be disparaged. But to prescribe drugs for a child whose symptoms stem from correctable social, familial, biological, or psychological disturbance without attempting to alter the factors causing the symptoms is a disservice to the child.

There is no assumption here that psychotherapy is necessarily any more of a specific than drug therapy. It, too, has symptomatic and nonspecific effects; exacting proof of its efficiency remains to be provided. It, too, can act as an anodyne if not accompanied by searching efforts to correct the untoward life stresses acting upon the youngster. The justification for psychotherapy appears to lie in its possibilities for modifying learned unhealthy behavior patterns. However, the patient may become accessible to psychotherapy only after the acuteness of his symptoms has been diminished by pharmacologic methods. It should be emphasized that control of symptoms by drugs is not an end in itself; symptom control provides a climate in which the patient can learn new and more effective patterns for coping with his environment.

Drugs have a definite but limited role in the treatment of disturbed behavior. Medical evaluation of new drugs seems to follow a time sequence characterized by: early enthusiasm, growing criticism and awareness of toxicity, premature calls for discard, and final sobriety with moderate agreement on indications and dangers. Drugs are neither the passport to a brave new world nor the gateway to hell. With thoughtful selection, careful regulation of dosage, and close scrutiny for toxicity, they add a significant element to a total plan of patient care.

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*An experiment with delinquents in . . .*

# SENDING THEM DOWN THE RIVER

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ON A BRIGHT morning in early June 1961, a heavy raft, pushed by two outboard motors, moved out into the Mississippi from the University of Minnesota campus and started down the river's main channel toward New Orleans, 1,764 miles ahead. The raft was a homemade affair, with a wooden deck as big as an average parlor floor, and that deck was loaded with sleeping bags, footlockers, cans of water, gasoline and oil, boxes full of food and, most important, 15 boys and 4 adults—the first adventurers in what was to become an annual river project sponsored by the Hennepin County Juvenile Court (Minneapolis, Minn.).

The boys had put all their optimism into just one word on the unprofessionally lettered sign that carried the craft's name, the "Unsinkable." To them the voyage was sheer adventure. To the staff and social agencies in back of the Unsinkable the voyage represented a serious experiment in therapy.

The idea of the voyage came from the boys themselves, but the atmosphere conducive to its birth and growth was provided by a group treatment effort known as the "Weekend Ranch Program." This program began in 1959, when the Minneapolis Post of the Volunteers of America offered the use of its Bar-None Ranch to the District Court's Department of Court Services, which provides probation services to the Juvenile Court. The ranch, with its 700 acres, was about 30 miles from town.

The plan which evolved was for a group of about 30 to 40 boys aged 12 to 14 needing intensive help to be selected from the probation caseload and given a group living-and-treatment experience every weekend. The age group was specified in order to provide a homogeneous group of children young enough to react with some enthusiasm to the ranch. The program's purpose was to keep the boys out of an institution by giving both them and their parents the help they needed.

The plan was to include some of the more seriously delinquent children from the probation caseload, excluding those handicapped by gross physical defects or unusually low IQ. Children would be selected who were markedly hostile and distrustful of adults, who had severe difficulties in getting along with their parents, and whose parents were especially inadequate. They would be children who were achieving far below their capacities in school and giving their teachers constant trouble. In short, they would be the children within the defined age group most likely soon to be on their way to a training school.

On the basis of these criteria the probation officers were asked to suggest candidates for the weekend program. One probation officer was made director of the program. He discussed the appropriateness of each candidate with the referring probation officer.

At this point all that was lacking was money—for the salaries of two or three part-time student workers, for transporting the children to and from the ranch, for feeding and bedding them for each weekend.

Fortunately, several businessmen in the community were interested in the two agencies and in the problem of juvenile delinquency. Drawn into the planning, they responded with pledges to support the

evolving program for a 3-year experimental period, and to serve as an informal advisory committee to the project. The element that particularly drew their interest was the proposed effort to work with both child and parents without removing the child from the home except for the 2 days of each weekend.

Each boy selected came into the weekend program for an indefinite period—from a few weeks up to a year and a half, or more—depending on the benefits he was receiving. The boys initially approached the weekend ranching with caution or even reluctance, since it was presented as a part of their probation plan. Parents too were indifferent. The plan was put to them in a juvenile court hearing where the judge made it emphatically clear that he expected both boy and parents to participate in the program. If the parents had strong reasons for objecting, the boy was not required to take part, but once they agreed to it they and the boy were expected to participate fully.

Every Friday after school a bus picked up the boys at arranged meeting points and got them to the ranch by suppertime. From then until Sunday afternoon their time was filled with a variety of assigned chores interspersed with a greater variety of recreational activities. All the usual housekeeping jobs had to be done, plus the farm chores. But for these city boys the program offered new kinds of fun with even the grubbiest jobs. Disposing of the garbage meant hitching two ponies to a cart and driving off through the woods to the dump. Cleaning the dairy barn meant a chance to romp in the hay afterward. There were horses to be cared for too, but this meant the excitement of horseback riding at other times.

All the boys had fun but all were boys with problems, and each showed his problems in his own special way. There were vicious temper outbursts. A boy would try to bully and dominate the group. Another boy would be markedly withdrawn, afraid either to fight or to play. One would steal from the others, while still another would proffer endless gifts of candy bars in an effort to obtain friends. More problems would appear at bedtime—bedwetting, masturbation, nightmares. The advanced schizoid condition of one boy became evident when he persisted in sleeping with a box over his head.

We soon saw that the weekend living experience had excellent diagnostic value. Under ordinary circumstances a probation officer could not get to know his charges as intimately as the Weekend Ranch Program staff learned to know these boys in the intensive 48-hour living situation each weekend. The boys' problems were revealed starkly in that close society.

However, since our main purpose was treatment, we used the diagnostic insights almost the moment they came in treatment efforts. The most specific treatment device was the Saturday night group discussion period, a free-ranging talkfest in which the staff leader participated just enough to keep the talk going in the most introspective directions. The boys criticized each other with gusto and raised questions of any kind that bothered them. They had usually observed enough behavior problems in the group that day to give them plenty of discussion material. The leader encouraged them to ask themselves why they behaved as they did and what better ways of solving problems there might be.

### *Parent Discussion Groups*

The parents had their own discussion groups on Sunday afternoons. They were divided into two groups, each group meeting every other Sunday. Each parent was expected to drive out to the ranch for at least six of these sessions. This requirement was tactfully but aggressively enforced even if the staff had to pick up and transport car-less parents to the ranch or otherwise circumvent the parents' excuses. Most of the parents came to these sessions reluctantly at first. Some may have been afraid of being lectured to or otherwise having their weaknesses held up to view; or they may have looked on the trip as a nuisance interfering with other Sunday plans. For some it meant the annoying necessity of staying sober for the day. But just as most of the boys became enthusiastic after a taste of the ranch life, most of the parents relaxed after a few sessions and seemed to get satisfaction from them.

These parents were accustomed to failure and to feeling blamed for their children's problems. Therefore, their initial conduct in the sessions was either a cautious reserve or a projecting defensiveness. Evidence of a growing satisfaction came gradually. Little by little they tended to talk more freely, to approach closer to a look at their own involvement in their children's problems instead of placing the blame elsewhere, and to exhibit a cautious willingness to see whether they themselves might make some personal change that would make things better for their sons. Some even showed up on the in-between Sundays when they were not required to come.

Always the group leader remained unobtrusive and let the parents find their own topics as they sat around a table supplied with coffee and cookies.

We regard these parents' group discussions as a

highly essential part of the whole treatment effort. Whether or not the experience effected change on the parents' part, it at least kept the parents keenly aware of what we were doing with their boys and helped to win their support. It gave us a better entree into the total family life than we usually have.

### *Birth of an Idea*

Since the weekend schedule was closely tied to the school week, we had to look forward to what could be done in the summer when the boys would be more available. During the first summer we began by conducting normal camp activities. However, on the third week we took all the boys on a 40-mile hike to an encampment in a State park, an activity which was to bring about a major new direction in the summer program. Several boys, thought to be ready for release from the program, on the hike exhibited their old problems: shop-lifting, stealing, general disrespect of property, difficulty in meeting adults or even other children. For the first time, problems could be seen and dealt with as they occurred.

As a result we planned another trip which would give the boys more involvement in community life and activity with staff control and guidance available. This was a canoe trip to the remote Canadian border country, planned to include frequent stops along the way—to fix meals, go sightseeing, hike at scenic spots, and to do necessary shopping. These stops were deliberately planned to provide the boys with contacts with other people. Before the trip staff and boys spent considerable time discussing attitudes toward stealing and property rights and ways of getting along with people.

The immediate result was a wonderful trip. The long-range result was the new program idea—the use of trips as a framework for treatment.

During the following year when summer plans were being discussed with the boys, several ideas for trips were considered. The boys' final choice was to build a raft and make a trip down the Mississippi. The planning for it began about 6 months ahead of the second summer vacation. The plan was for all 30 boys in the Weekend Ranch Program to be involved in the river trip; half would travel on the downstream trip and the other 15 would go to New Orleans by bus and ride the raft on its return trip upstream. However, we had a few things to learn.

The plan was popular with the boys but not with everyone else. For a probation worker to float down the river all the summer with a bunch of boys is not the conventional way of doing probation work. Some people wondered whether the trip would not seem to be a reward instead of a proper punishment for delinquency. Some assumed that it would be just a lark. The idea and the reasons behind it had to be discussed thoroughly with the authorities before it could be assured of the essential official support.

The Department of Court Services is administered by the District Court of Hennepin County, which has the freedom to permit and support any kind of treatment program that its judges regard as being a proper function of a probation service. Because of the unconventionality of a river trip as a probation method, the judges were initially somewhat skeptical of the proposal. Therefore, several persons with long experience in YMCA or other social group work programs were asked to meet with some of the judges and the probation staff to discuss it. After numerous questions had been asked and all apprehensions aired, they agreed that the idea was sound enough to justify a trial, and the court gave its assent.

In planning the trip we were looking at certain severely handicapping characteristics typical of the boys in this program. They were from families with narrow horizons who seldom took trips or even talked about things that went on elsewhere in the country or the world. They knew little about any geography beyond their own neighborhoods or of historical and cultural differences elsewhere. Their families had few goals for them, educational or otherwise. The boys had no motivation to stay in or do well in school for they had no notion that anything being taught them would have practical use in their lives.

The river trip provided a way to attack such deficiencies. Boys who never planned ahead for more than a few hours were for the first time engaged in sustained planning for an event that was 6 months away—an event exciting enough to catch their imagination and hold their attention through all that time. Boys who scorned arithmetic in school found themselves struggling willingly with numbers as they computed the buoyancy of an oil barrel and went on from there to determine how much weight the total raft would sustain and so how much gasoline could be taken along, plus food, sleeping bags, and people.

Boys who never had given a thought to the world beyond their own neighborhoods and had rejected geography in the classroom found themselves studying maps to pick the towns along the way where stops would have to be made for fuel, food, and water. Next they wrote letters to the mayors of these towns to find out whether they had docking facilities and whether gasoline and other supplies would be avail-

able—for the first time using their school lessons in how to write a proper letter. When the answers to their letters began to come in, boys who had always felt rejected by people in authority had the heady experience of being welcomed by the mayors of town after town and assured that they would be greeted and served on their arrival.

Meanwhile the raft was being built and the boys worked on its construction every weekend. Forty borrowed oil drums were arranged in four rows to serve as pontoons. Lumber donated from Army surplus was worked into a platform over the pontoons. One boy who had consistently failed in school stood before the group one evening and competently explained how he had computed the number of square feet of surface for each oil barrel to determine how much paint would be needed to cover them all.

Since an endeavor such as this inevitably raises visions of possible accidents, illnesses, and even drownings, we discussed problems of liability with our county attorney. He informed us that we were in a fully defensible position if the trip was in the hands of competent staff; if the parents were fully advised of the venture and freely consenting; if the boys had prior instruction in all appropriate safety measures; and if all the desirable safety precautions were taken on the trip. Meeting these conditions presented no problem. Representatives of the Army Corps of Engineers, the Coast Guard, and the Red Cross came to the ranch to speak to the boys on first aid, water safety, and navigation. Safety rules were then developed by the group: Life jackets were to be worn at all times on the water; no swimming was to be done except when the raft was tied up and after staff had designated a safe swimming area.

An insurance policy similar to the type usually available to camps gave us coverage in respect to accidents, illnesses, and other hazards.

Obtaining parental consent might have been a problem if there had been no parent discussion groups. These had given the parents ample opportunity to hear of the plans from the beginning and to ask the director whatever questions they had about any aspect, to make suggestions, or voice objections. As the time for the trip came near each parent was asked to give a signed consent, and the parents of all but one boy willingly did so. He did not go.

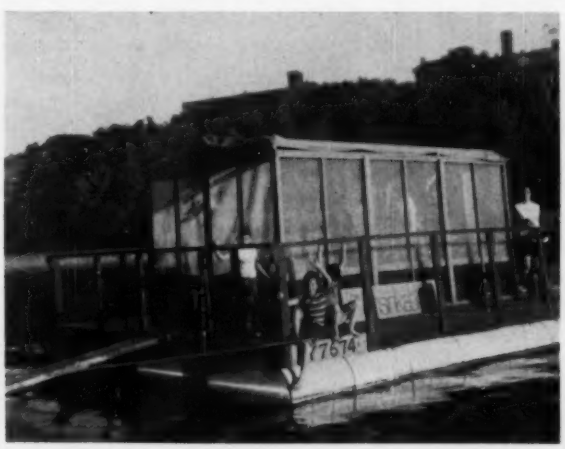
This process not only developed parental consent in a natural way, but in some cases it gave parents and boy a common interest that they had previously badly lacked. On the early morning that the Unsinkable finally began its voyage, nearly all the parents were on hand to see it off.

To live all day, every day with 15 boys on a deck measuring 16 by 33 feet is confining and could be nerve-racking. It was made tolerable by the immense variety of the passing scene. Every bend of the river brought a new vista and every day brought its quota of new wildlife to see, barge tows to wave at, locks to go through, fishing to be done. The boys themselves did nearly all the navigating, cooking, and cleaning up. The close living required an interdependence that was a good new experience for them and also had superb diagnostic value for the staff.

The treatment elements were of several kinds, some arising from the natural daily situations and some

Boys at the Bar-None Ranch constructing the Unsinkable.

The Unsinkable ready for the long voyage down the river.



contrived by the staff members on the raft. Some boys obtained real help from just being away from their homes in an exciting and satisfying living situation. Daily life with strong and likable adults was undoubtedly another helping factor. Certainly some of their new experiences also had a constructive effect. For example, coming into one town on the heels of a severe storm the boys found that many boats along the dock were being swamped and washed away, and they struggled energetically to help save them. The next day they found themselves described in the local paper as heroes. This and other experiences with admiring city officials all along the river gave them a taste of the pleasure of being recognized for constructive rather than destructive acts.

There were also negative experiences, usually a cropping up of old problems. In group discussions around the fire ashore in the evenings the staff exploited both positive and negative experiences.

Twenty-eight days after the pushoff from Minneapolis the boys were in the busy main channel of river traffic in New Orleans. After a few days of sightseeing in the town they returned home by bus.

According to the original plan, the second group of boys, having arrived by bus, started the return trip upstream on the raft. "Ol' Miss" was not so agreeable to this, and we found that our power was not equal to the job of getting the raft back in time for the start of school. So these boys completed the return trip by bus.

### *An Overview*

The Weekend Ranch Program is now 4 years old and the river trip has been used in three of the four summers, including the 1964 season. Many modifications have been made as we have gained experience—including shortening the trip, with St. Louis as the destination—but the basic plan will be continued. Not everyone has a Mississippi River so nearby to go drifting on, but the essential idea of the tripping program is packed with treatment potential that might be utilized on various kinds of trips.

We naturally have wondered if the program could be expanded to involve a greater number of boys, for as it is it represents a heavy investment in staff time for a rather small group. We would like to see it expanded if expansion means having more group projects rather than just adding more boys to this project. Thirty boys is probably the largest number that can be handled successfully in one project and may be too large unless the selection process has been skillful. A larger group will threaten the control of group dynamics and exhaust available staff time.

The program director can spread himself only so thin. While most of the year his program is actually in process only 48 hours a week he has an immense amount of planning to do; he must spend time regularly each week in training his part-time assistants; and he must meet frequently with probation officers who want to refer new boys to the program or ask about boys already in it. Emergencies require time to be spent during the week with the boys' parents, or their teachers, or the boys themselves.

Expansion, in the sense of adding more such projects, should be feasible—if enough money and competent professional staff are available.

However, there would be no point in extending a replica of this program to many of the young people in a typical probation caseload. One reason for its effectiveness is that it has been designed to meet the needs of a narrowly defined group of children. If a number of group projects are to be instituted within one probation department, it would be better to have each one designed to serve a different type of child and to revolve around a different type of activity.

When we started the Weekend Ranch Program we were more concerned with an action project than with research, though we did want to evaluate our work as reliably as possible. We tried to develop a control group for comparison but encountered some insoluble problems in selecting the controls. We finally settled for an orderly process of subjectively evaluating each boy before, during, and after his involvement in the program, on the basis of school, court, and police records as well as personal observations by his probation officer and the program staff.

Among the 56 boys who were admitted to the Weekend Ranch Program in the first 2 years, 4 did not stay in the program long enough to be helped; they got into more trouble and were sent to institutions before the program could affect them.

Of the 42 boys who stayed with the program for 12 or more sessions, 33 seemed to improve. In some instances this was apparent in nothing more than a cessation or a substantial reduction of delinquent activity. In other cases it showed also in school behavior and academic progress. In six cases improvement was dramatic. In general the boys who were the most disturbed were the ones who seemed to make the most progress. Following the trip they showed some regression in adjustment but only a partial regression, with a satisfying net gain remaining.

Such gains support our faith in the value of combining therapy with adventure.

*How the residents of a housing project in Houston have been roused into . . .*

# WORKING TOGETHER FOR NEIGHBORHOOD IMPROVEMENT

CORRINNE S. TSANOFF
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*Houston, Tex.*

A BAFFLING and tantalizing problem for those who work in settlement and neighborhood centers is how to involve an entire low-income neighborhood in a large-scale effort to improve and develop itself. Experience shows that some people will participate in an improvement program, become leaders, take responsibility—but many more will remain anonymous, withdrawn, apathetic. For many persons, the procedures for getting the kind of service they need are too unpleasant to think about.

Five years ago, Neighborhood Centers Association of Houston and Harris County (Tex.) initiated an experimental action program in one such neighborhood. The program had two major objectives: (1) to see whether a whole neighborhood, with a trained staff to guide it, could become involved in a program to better itself and develop its own leadership; (2) to tell the residents of the city's special services and persuade them to use these services, not only in crisis but as part of a coordinated and continuing program. The planners had another hope: that through this program of self-help and development, the residents would get a better understanding of the meaning of the democratic process. Neighborhood Centers was already working in what it considered an ideal unit for such a program: Clayton Homes, a public housing project where parents were slow to enroll their children in school, delinquency was high, and dropping out of school was common.

Clayton Homes, built in 1952, has 348 families, about 1,500 persons, and was built on land reclaimed from a bad slum area. It is an isolated community—separated from any normal neighborhood by the Eastex Freeway and railroad tracks, by Buffalo Bayou, and by industrial warehouses. The nearest market is a mile away. The two-story buildings have yard space around them and there is a small playground at one end of the project. Just outside the playground fence, along the banks of the bayou, Houston industries used to dump their garbage.

The people who live here are Mexicans, some recent immigrants, others second generation. They have large families and many families have no father at home. They are unskilled workers with low incomes. Many of them are illiterate in Spanish and unable to speak English. There is a high incidence of sickness, disability, dependency, and family breakdown.

Neighborhood Centers had conducted a routine settlement program in Clayton Homes until 1959. Our staff, consisting of social group workers, expressed doubts about whether the residents could be roused into taking active interest in affairs outside their own families and their immediate needs. The first step, therefore, was the preparation of our staff

through considerable discussion and seminars. The next was to drop membership requirements to participate in Neighborhood Centers.

Late in 1959, the staff was ready and we held a meeting to outline the plan to the people of Clayton Homes. They showed no resentment at the necessary surveys and the strange consultants. On the contrary, they seemed interested and pleased to know that others were really concerned about their well-being. They chose as a name for the program "Neighborhood Development" rather than "Neighborhood Improvement" because they felt it expressed a more constructive attitude. "Improvement" seemed to imply that something was wrong with them.

### *Getting Under Way*

The staff decided on three self-help projects in an attempt to interest everyone: a Christmas festival, a cleanup of the project grounds, and a kindergarten readiness program. The community was divided into six sections, each with a leader, and a committee of the leaders was set up.

The festival was the first project because Christmas was close. In previous years the several hundred dollars contributed by the Clayton family at Christmas bought gifts for the children. But for Christmas 1959, the committee used the money to buy and sack fruit. On Christmas Eve they took a sack to the door of each family with a recipe for fruit salad, wished everyone a Merry Christmas and invited all to join their section's procession to the recreation building for the Christmas program. Each procession had its Madonna, and the Madonna of the largest procession was to be the Madonna of the crèche. The smooth execution of the Christmas program gave everyone a glimpse of the possibility of working together.

Other projects followed, at first proposed by the staff, and later by the residents themselves: deroaching apartments, getting Houston's sanitation department to eradicate the rat menace, protesting the dumping of refuse at their fence. Without total cooperation, these cleanup campaigns could not have been effective. They were effective, and they are now annual projects.

Group spirit increased. The sections decided to elect leadership committees annually and a committee chairman every 4 months. This was disturbing at first for persons accustomed to be leaders in every project, but its value in uncovering potentialities among residents is constantly demonstrated. At first only women were interested, but now seven men hold offices and many more are active in projects. Increasingly, the Neighborhood Centers' staff has let the suggestions come from the residents themselves.

The community next took on the problem of education. Every family in Clayton Homes with a child of kindergarten or first-grade age was visited by a committee member or a staff person who explained the requirements for enrolling in public school and the advantages of regular attendance. The committee held a reception and invited the principal and school nurse of the elementary school and the mothers of the children who would attend the school. Both principal and nurse spoke effectively on the advantages of a child being ready to enter school on the first day. As a result of these talks, every child had his shots and vaccination and was at school with his mother to enroll on opening day. The school has participated in similar kindergarten readiness programs held at the housing project for the past 4 years and in its two neighborhood art exhibits. The principal has also met with small groups to discuss differences in education in Mexico and the United States; how parents can help children study; effective discipline; what school achievement can be expected of children at different ages; the influence of home on school achievement; and the value of education to the child.

From their concern with their children's education, the parents turned to themselves. For 3 years, two evenings a week, they have been taking night classes in English and citizenship courses at a public high school. The home-management committee has sponsored cooking and sewing classes for women and girls.

Last year the committee put up outside Christmas decorations for the entire housing project. Several persons had warned that teenagers would tear them down, but many others had replied: "Not if we put them up." Not one decoration was destroyed. A washateria, built by fiesta funds and outside contributions, and a limited grocery store are managed by residents under direction of Neighborhood Centers.

Thus, the people of Clayton Homes grew in self-confidence and understanding as they came to grips with many problems that had formerly overwhelmed them. Where necessary, the staff members provided guidance to make workable projects out of suggestions.

### *The Problem of Teenagers*

The attitudes and behavior of the teenagers were a grave concern to their parents and the community. A new program to win their participation in neigh-

borhood improvement was needed. In June 1962, as part of the Sabin polio vaccine campaign, the chairman of each adult section recruited two teenagers from his section. Together they attended a meeting to plan the participation of teenagers in the campaign. The youngsters adopted the sectional organization of the adults and elected officers. They recruited other teenagers to work at section headquarters. They arranged for a special bus to take teenagers to the vaccination center. Ninety-seven percent of the youth of Clayton Homes were vaccinated.

After this flying start, the youth leadership committee decided to sponsor parties, dances, and field trips. To train them for leadership responsibilities, the Neighborhood Centers' staff took them to an out-of-town camp for a 2-day retreat. There the staff explored the youngsters' needs, interests, and attitudes. The youngsters said they wondered what their neighborhood friends would think of them and whether they would participate in the plan. They expressed a need for activities outside of school "because we hardly ever get a chance to take part in special activities in school." But they realized they needed to learn how to work in community programs. They also pointed to the need for activities for boys and girls who are always in trouble "because they need attention."

After some get-acquainted activities, the teenagers organized a skating party, theater party, and a dance. In March 1963, they held their first election for a leadership committee. Of 162 teenagers, ages 14–19, in Clayton Homes, 151 voted. The elected leaders went on a 2-day retreat to become acquainted with their new responsibilities. They had training sessions during the first 6 weeks in office.

From the adult and youth leadership committees a Neighborhood Council to deal with policies and activities of the whole community was formed.

In the summer of 1963, the youth committee and the staff, working together, arranged for a preemployment and work training program for boys and girls. Adapted to the young people's inclinations and abilities, the program included typing, filing, work with cars, kitchen and janitor service, baby sitting, and home economics. The participants were rewarded by trips to interesting places all over Texas. To earn money for these trips, the girls won agreement from several construction firms in Houston to let them clean up newly built apartment houses. They did this in teams. The response of Clayton Homes' youth to this program was especially gratifying because other agencies involved with them doubted its chances of success.

Service to neighbors is also emphasized in the teenagers' program; some of them have even "adopted" elderly residents who need their help.

### *Coordination of Services*

When the neighborhood experiment began, over 32 special agencies were in and out of Clayton Homes on more or less emergency requests. Their services were not coordinated; indeed, many agencies did not know the others were present. And too often the services were poorly understood or accepted by the people who needed them most.

As the second phase of our experiment, we sought acceptance by all agencies of an integrated program so that their services could be understood, desired, and requested before the agencies offered them. Neighborhood Centers took on the responsibility of developing this understanding and acceptance. This proposal was to apply particularly to new services rather than to the established and known services.

To win support for the program, the director and assistant director of Neighborhood Centers Association visited the leaders of each agency they thought might be interested in helping the development of Clayton Homes. In April 1962, an administrative commission, representing the boards of all interested agencies, was set up under the chairmanship of a board member of Neighborhood Centers Association. This commission sees that the program's policies do not conflict with their agencies' policies, advises on how the agencies could best contribute to the program, and follows up suggestions.

The Neighborhood Council of Clayton Homes, with staff help, suggests activities it would like to see included in the program and submits them to the administrative commission and to the city board of Neighborhood Centers for approval.

There is also an administrative advisory committee, made up of agency executives, to keep the agencies in touch with the needs of the community and its progress, a technical committee of supervisors of agencies with workers in the project, and an operating committee of all staff personnel working in the neighborhood. Also, volunteers with skills in vocational employment counseling, law, homemaking, counseling and education in family life, leisure time activities, and in mental and physical health problems were invited to participate.

After 4 years of intensive work in neighborhood development, we see leadership developed in Clayton

Homes to an extent that surprises even the staff. The residents have learned of their abilities to confront and to solve many of their problems—and this has increased initiative and self-reliance. Their ability to work together has nurtured community spirit. Unmet needs have been uncovered and special services established to care for them.

The juvenile court probation officer and the police department's juvenile division report a noticeable reduction in unsocial behavior. Children are enrolled in school promptly. The school reports better general attendance than in previous years. There has been a noticeable change in parental attitude toward education. The director of the city housing authority maintains that the entire atmosphere of Clayton Homes has improved markedly. "The people were cold and unfriendly toward each other. Now they know each other and work well together. Vandalism has noticeably lessened."

The cochairman of an adult leadership committee has said that when he moved into Clayton Homes 3 years ago he knew no one. He attended a general meeting and became interested in working with boys. He has now signed up 16 other fathers to sponsor scout troops. Five boys were such troublemakers that the fathers wanted them kept out. "But I told them," the cochairman said, "they are our boys and we must get hold of them. Three of the five now belong and no longer are troublesome."

Of course, problems remain: incomes are still low, families are still large, family breakdown occurs. As in any community, personalities sometimes clash, and status means a great deal. Some committee members have resisted broadening the base from which leaders arise; they enjoy their status and hope to retain their elected positions. We regard this problem as arising from human traits rather than failures of method. But we ask: Can neighborhood development overcome both the unwillingness to assume responsibility and the desire to retain too much responsibility? Can we keep committees from stagnating without stimulation from the staff? How much responsibility can a neighborhood leader be expected to carry? Most of the residents, especially the men, work long hours and have little time or energy for community affairs.

We have derived much information from our project and are now ready to introduce the techniques and tools used in Clayton Homes into comparable neighborhoods within our larger district of operation. We shall use Clayton Homes as a laboratory training center for developing "multipurpose" professional staff for working in integrated service projects and developing indigenous leadership in these other communities. We shall also count on help from Clayton residents, who are often able and willing to report their neighborhood's progress.

We share a serious difficulty with every participating agency—lack of operating staff trained for this type of neighborhood development procedure. In the past, social workers have been educated to identify the problems, recognized by our own standards, and to offer solutions. But in our work the staff must first listen before they talk. Centralized agencies with highly trained staff find it difficult to adapt themselves to this level of operation.

### *New Outlook Needed*

People in deprived neighborhoods need help when their emergencies occur. They find it difficult or impossible to make appointments a week or more ahead to talk over difficulties which may no longer be in their focus of attention, though they may be lurking in the background with bad effects. Filling questionnaires is an insuperable obstacle to the illiterate person. Many poor people distrust the person across the desk; they leave an office bewildered and never return.

Centralized agencies are willing to send workers into a neighborhood for specified hours for consultation—but the idea of establishing services with which residents can identify and which they can use in emergencies seems difficult for them to accept. Should agencies require that the client be trained to accept their services, or should they train workers to offer services on a neighborhood level where people can and will accept them? If our health, family welfare, and recreation agencies intend to help the most deprived part of our population, our minority groups, they must unlearn some techniques and devise new ones for listening to, interpreting, and meeting the needs of these people. Until this is done, a great obstacle to helping deprived persons will remain.

Every social agency wants to help, but footing it out in a neighborhood is more tiring than the desk interview, and even settlement workers, trained for neighborhood service, often wear out in the process. Somehow our specialized social work procedures must find a new outlook—perhaps area services established by and recognized in the neighborhoods they serve, with staff members close to the people and recognized as friends. Such centers could represent several agencies.

An old settlement byword says: "The people who need you, need you near." The need is pressing.

# CASEWORK WITH A CHILD FOLLOWING HEART SURGERY

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IN A ROOM on the cardiac surgical service of a large research hospital, an 8-year-old boy was engaged in a physical and emotional struggle for life. His name was Tim and he was afraid. As Tim's social worker, I was concerned with his fear, a fear that remained even beyond the immediate physical crisis. As his health slowly began to return, I tried to help this weakened boy wrestle with his fears and nightmares.

The emotional needs of young children during hospitalization are usually met through the security and understanding of the parent-child relationship. Therefore, casework efforts are usually concentrated on helping parents handle their feelings and attitudes so they can be most helpful to their child. Occasionally, however, parents become so overwhelmed or have such a distorted relationship with their child that they are unable to sustain him and direct casework with the child becomes necessary. Such was the case with Tim.

His home broken by his mother's divorce from a psychotic father, Tim lived with two younger siblings and a narcissistic, masochistic mother, herself the product of a disturbed home and ineffectual parents. She appeared to court crisis and disorganization in the family and in her own life and to reject Tim.

During Tim's most critical days his mother was demanding and unsupportive, and Tim reacted by withdrawal and depression. Failure of attempts to help her with her relationship with her son, and the extent of Tim's critical emotional needs, made me decide to work directly with him.

Tim was suspicious of strangers. Many new consulting doctors had been seeing him to control postoperative complications; their visits often signaled new and frightening treatments. When I introduced myself as a social worker who wanted to talk to him, Tim said he had just had another heart operation and did not like all the needles he was getting. For several days we talked about his treatments and his family and played some games. On the fourth day I suggested that we form a club to meet, talk, and play together regularly. Tim said he would like that. When I asked him what we should name the club, he answered, "The Two Men Club"—a tangible expression of his need and readiness for a special relationship. I soon turned my office into our clubroom and, whenever possible, wheeled Tim from the ward to our room.

I hoped to achieve several purposes: to learn how the hospital experience was affecting Tim so I could help him master it, for now and the future; to be a patient, understanding person unconnected with his treatments and medicine, to whom he could talk about his daily ups and downs and thus to help him to accept and benefit from his difficult medical regimen. The club would be a place where he could assert his independence, make decisions rather than simply obey them, talk about new things, have new experiences,

and be encouraged, within the hospital limitations, to exercise a boy's natural curiosity. Finally, I hoped our relationship would provide Tim with confidence to express his feelings and give him the experience of having a healthy male relationship.

### *The Early Sessions*

During our first few meetings, we made clay club badges for ourselves and signs and decorations for the club room. Tim participated eagerly as far as his meager energy allowed. However, he was protective of his thoughts and feelings and quickly changed the subject any time I mentioned his illness. I began to tell stories about an imaginary Robby Robin who fell from his nest. When I asked Tim what happened then, he said that Robby's mother called the doctor. I asked whether Robby was hurt and had to go to the hospital. Tim became tense and said emphatically, "No," Robby was not hurt at all. Several days later I asked if we should tell a story about a boy instead of a robin, and he replied softly, but firmly, "Not about me."

I did not want to push Tim. We played games, finger painted, and visited the gift shop, the patients' library, and the room with the experimental animals. He responded eagerly to these new experiences, but in his creative play, his art work, and his relationship with me (except for constant complaints about shots) he was restrained and rejected any reference to his own thoughts or experiences. In our play with a doctor's kit, he refused to find anything wrong with the doll patient and would not give shots or medication.

During the second week, while we were finger painting, Tim said very quietly that he could not fall asleep the night before. (The nurses had told me Tim was sleeping fitfully and had a troubled expression on his face while asleep.) When I asked him why, he looked away for a moment and then said easily that he was worried about his roommate who had had a seizure several days before. We had discussed this frightening experience before in a special club meeting I had called the night it happened, so I did not think this was Tim's real worry. But I did not press him.

Over the next week our relationship deepened. We talked more about his troubled sleep and the "worries" that kept him awake, but he could not get himself to tell me what was worrying him. We made two evening trips to the roof to view a newly launched weather satellite. I gave Tim a picture postcard I brought back after a 2-day absence. He kept it inside his shirt. He continued to reach out for new experiences and became more relaxed and spontaneous in our club play.

A turning point came at the beginning of our third week as Tim pointedly tested our relationship. I mentioned the possibility that he might go home in 2 weeks. He did not respond to this. Instead, he told me that several other patients had asked to join our club. I told him that this was the "Two Men Club" and that our membership was full. I repeated what I had told him many times: I was his social worker and the club was for us to talk and do things together. He seemed relieved, then asked what would happen to the club when he went home. I told him that I might be able to visit him there. He seemed very pleased and said, "Maybe we can find a cabin or a little home where the 'Two Men Club' can meet all alone." During this period he checked my whereabouts constantly. I recognized his need to test me before he could go further with our relationship, so I responded to his demands as much as I could.

### *A New Emphasis*

On the following day we began 10 days of club meetings very different from those of the previous 3 weeks. The emphasis turned from play to talk, a switch Tim himself initiated. During the previous 3 weeks we had used the dictaphone in my office, talking into it and playing it back. Occasionally, I told a story on it. Tim was a little hesitant to record his voice, but he enjoyed the playback. His recordings usually told what he had done the day before. On this day I asked Tim if he wanted to tell a story on a record. Since we had visited the animal room, I suggested it be about an animal. He told the following story:

**Once upon a time there was a little mouse who did not have nobody to play with and nobody to love him. One day he went out for a walk into the far, far forest. A lot of animals were crying for help because the big elephant was chasing them. The little, little mouse grabbed the big, big elephant's tail and swung it around his head and threw him out of the jungle. He was the bravest mouse in the whole world, and he grew up to be a guinea pig.**

As we played the story back, Tim looked frightened and held his ears. When I told him we did not have to play it back, he insisted that he wanted to hear it. This was the first glimpse Tim had allowed me of the world in which he was struggling.

There followed three successive club meetings devoted to stories, all told at Tim's suggestion and all heard back with covered ears and frightened expression. They told of a world of fear, impotence, vio-

lence, and helplessness. These were the stories of the two succeeding days:

**Once upon a time there was a little baby elephant named Panda. He took a walk in the forest where he came upon a big, big deer, and he said "Hello" to the deer, and the deer said, "Why, hello," and they were pals. They walked through the forest until they came to this beaver, and the beaver said, "You have a spear. I want a spear, but how do I get one?" "Here's one," cried the little beaver, so they started out for another walk, and they saw this hunter, and he had a gun, and he was going to shoot them. So they ran back and locked their doors and lived happily ever after.**

* * *

**Once upon a time there was a big dinosaur who thought he was going to die, and he said to himself, "I am going to die, I know it, I'm going to die." He walked through the forest and all the other animals were happy but he was the only one who was sad because he was sick.**

On the following day we played back some of the old records. The last one told about Robby Robin falling out of his nest. Tim hastened to say that nothing at all had happened to Robby and that he needed neither doctor nor hospital. At this point I had to terminate the meeting and left Tim alone at his request to make a record on his own. This is the record:

**Today when Tim and Mr. Richman had a meeting of the club, he could not stay long, so we made a couple of records and we listened to them, and after that he went home, I mean where he was going to go. He did not have much time so he got the record player and let me make a record while he was gone. So I did. I made a record and listened to it and I had so much fun that I could not bear to tell this and it was: Once upon a time there was this little robin named Robby Robin, and he set out in the far, far forest, and Robby did not like the animals. One day this great, great big hunter came and he was hunting a whole lot of birds and he killed Robby.**

While I recognized the great significance of these stories for Tim, I chose not to discuss them with him. He was getting along well in the ward and club, and I saw the stories not as alarms but as Tim's own way of working out his anxiety about his illness and surgery, within the safe context of our relationship.

Several days later Tim indicated that he needed more direct help. Important visitors were at the hospital and Tim's surgeon was going to speak to them about new advances in heart surgery. Five postoperative children were brought to the solarium to meet the visitors before the surgeon's talk. I saw Tim about an hour after the visitors left and he appeared rather dejected. When I asked how the morning had gone, he replied, "OK," but he had not been allowed to hear the surgeon's talk. When I asked about his interest in the talk, he became very tense, said he did not want to talk any more, and mumbled something about "what he used." Later that afternoon I saw Tim on the unit and he asked me where I was going after work. He had never done this before, but he would not tell me why he wanted to know. I gave him my telephone number and told him he could call me if he needed me.

The next day I suggested that we talk about the operation. He was reluctant, but I pressed him a little, telling him that I thought I could help him. Then I asked several direct questions: Had he been scared of the operation? Did it still frighten him? Was he worried about it? To each question he answered in a small voice, "Yes," and began to look frightened. Tears began to roll down his cheeks, but he was not sobbing, and he looked at me as though he wanted me to go on. I said I knew it was hard for him to think about it, but that if we talked about it a little more he might feel better. Then I asked if he could tell me what it was about the operation that he found so scary. The tears continued and he struggled for several minutes before he could whisper, "The knife." This admission brought on real crying for several minutes. When he was calmer I asked Tim to describe the knife. He drew, hesitantly, a picture of a large curved knife with a sharp toothed edge.

When I asked how long he thought it was, he held his hands about 2 feet apart. When I asked what about the knife worried him, he replied, "What they do with it." I asked when he thought about it, and he said, "All the time." When was it the worst? He said, "At night, when I dream about it." Still crying quietly, he told me about the dream that came every night: A huge figure chasing him, wielding an enormous knife. Did other things frighten him? Tim looked at the floor and asked if the blood clots he coughed up were pieces of his heart.

As he used up his meager energy crying out some of his fears, Tim came close to me and held my arm. I held him for a few minutes, told him I knew that his fears were real and painful, and reassured him about the size of the knife (really only 4 inches) and the coughing. I could not reassure him that he would not have to undergo the knife again; instead, I emphasized his great progress over the last 3 weeks. No words or gestures, however, could really soothe the starkness of his terror. I hoped that my presence and our mutual trust would lighten the burden of his fears.

During the next days the nurse reported that Tim's

sleeping seemed less disturbed, and 3 days later Tim told me he had not had the knife nightmare. Later he reported that the nightmare recurred the night before he left the hospital.

Three days after our interview about the knife, the doctors decided that Tim could go home the following week and report weekly to our outpatient clinic. He would, however, have to remain quiet and be watched closely.

Tim was reluctant even to talk about going home, so I began the following story. At certain points I stopped and asked him to take over.

*Worker:* Once upon a time there was a frog. His name was Fog, Fog the Frog. And Fog the Frog lived in a bog. And Fog the Frog who lived in a bog liked to sit in the mud, and he croaked in the mud. He went: Glug, glug, glug. And one day the people from the hospital saw Fog the Frog in the bog and they said: "We think we should take Fog the Frog out of the bog and bring him to the hospital." So they asked Fog the Frog whether he would leave the bog and come with them. He said—

*Tim:* "Yes."

*Worker:* So they took Fog the Frog out of the bog and brought him to the hospital—

*Tim:* and the hospital took science research on him, just any kind of research—

*Worker:* and he sat in his little glass house on the seventh floor in the animal room and he went glug, glug, glug. And he thought about where he was, and this is what he thought.

*Tim:* He didn't like it in the animal room very much—

*Worker:* and the little mouse who was his nextdoor neighbor said to the frog, "Why don't you like it at the hospital here in the animal room?" And the frog said—

*Tim:* "I don't have any water."

*Worker:* Fog the Frog belongs in the bog. But he stayed here for a while, and finally there came a time when he just decided that it was time to go back to the bog, but he didn't know if he wanted to go back to the bog or not because—

*Tim:* his friend, the mouse, was his nextdoor neighbor—

*Worker:* and they liked each other, and he couldn't decide whether to go home to the bog or to stay at the hospital. And he thought and thought and he decided—

*Tim:* to stay at the hospital with his friend the little mouse.

In view of Tim's ambivalence about going home and his investment in our relationship, I decided to continue seeing him during the transition period. Tim's mother had first asked for this plan and she cooperated fully. The time factor and hospital policy dictated that this arrangement could be only temporary. We agreed on a maximum of 12 months.

I visited Tim the day after he went home and then at biweekly intervals for 2 weeks and weekly thereafter. His physical condition continued to improve and with TV and toys he was keeping himself amused. Our interviews centered on his daily activities and did not deal with any new issues. Since Tim was a child who responded eagerly to new experiences and opportunities, I sought community resources which could help him lead as active a life as he could physically handle. At the same time I was paving the way toward ending my own work with him.

The first priority for Tim was school. He was already a year behind, and for future social as well as academic reasons I was anxious that he not fall further behind. A teacher from the county board of education began concentrated first-grade instruction at his home. A warm, cheerful woman, her thrice-weekly visits provided a new, engaging relationship for him. In addition, an occupational therapist from the county tuberculosis and heart association visited Tim once a week, leaving craft projects and new games which delighted him. He was soon busy making little gifts for everyone he could think of, including a carefully stitched leather key case for me.

### *The Caseworker Withdraws*

Tim's physical condition improved rapidly. With the early spring weather he was soon outside making friends with the neighbors and playing in the yard. Since he would probably be well enough to go to public school in the fall, I thought it would be helpful for him to have a group experience with normal children beforehand. After a long search, I finally found an excellent day camp for healthy children which would accept him. Located on the grounds of a private school, the camp emphasized crafts, nature study, and sports. Our doctors endorsed Tim's attendance, and the camp director was carefully informed of the boy's limitations and special needs. Our faith in Tim's emotional stability and ability to adjust was wholly vindicated at camp. He fitted into the group beautifully and achieved poise and satisfaction. Visiting one afternoon at Tim's invitation, I saw him try to keep up with his friends in a swimming race. He got tired and a little blue, pulled himself out of the pool, and obviously unhappy, slowly dried himself in a far corner. After a while he came over to me with a smile and led me to the arts and crafts shop to show off the wastebasket he had made for me.

School began, and I visited Tim at home twice in the first month. He was in the second grade and doing well. He got along well with his classmates, but during the first 3 months he had to be helped to limit his outdoor activity to his physical capabilities. Therefore, I visited the school to talk with the prin-

cipal about Tim's physical condition. Tim knew about my visit and was pleased.

As Tim associated more with healthy children, it became apparent that he felt more and more pressed to keep up with their activities. Eight-year-old boys place a high premium on activity and Tim was not able to keep up. For his own self-confidence and social development he needed to find some areas in which he could achieve and excel. I arranged for him to join a small Cub Scout troop, where he could develop his interest in scouting skills and nature lore. He responded enthusiastically and gradually became less frustrated at his limitations in the schoolyard.

Ten months after Tim had left the hospital, he and I agreed, both reluctantly, that we would not get together except when he came for a clinic visit. At this time, I arranged with the Big Brothers of America to provide him with a Big Brother. The Big Brother selected was a family man with a farm outside the city and a strong interest in nature study and outdoor life—an excellent person to provide Tim with the male companionship, identification, and understanding that he now needed so much more on the personal than the professional level.

Three months after my last visit to Tim's house he came into the clinic. His heart was still not well, but he had lost some of the pasty look of a chronically ill child. As we finished a game of darts in my office, he bent over the dictaphone and asked if he could make a record. I was surprised because I thought that our records held bad memories for him. I gave him a blank disc. He hesitated, then asked if he could tell a story alone. I told him I would wait outside. Five minutes later he opened the door and beckoned, then began to play the record he had just made. From the dictaphone came a clear, confident voice—not the hesitant, frightened voice of a year ago.

**I have a friend who is Mr. Richman. This is a story about him. Once I had a friend named Mr. Richman. He was a good friend. One day I was going to the store and I met him. I had a bag of popcorn and it was all falling out, so he helped me, and we got home fine. Then when we got home, he ate lunch with us, and then he went home.**

**The end.**

Then Tim picked out an old record at random and played part of it. When he came to the description of the mouse who was so frightened, he smiled and said, "That was me." Impressed with the contrast between Tim on this day and the day he left the hospital, I asked him if he remembered our story about Fog the Frog. When he said he did, I reminded him that we never really knew what happened to Fog, and suggested that we finish the story just for fun.

***Worker:*** **This is the second story about Fog the Frog, who used to live in the bog. Fog came out of the bog when the people from the hospital came and brought him here, and he stayed here for a while in the animal room until it was time for him to go back to the bog. So Fog the Frog went back to the bog and now we want to find out what happened when he got back to the bog.**

***Tim:*** **When Fog the Frog got back to the bog he went on his lily pad. Since he wasn't near his lily pad, it was all soaked up because of the rain, but Fog the Frog who lived in the bog got out a new one. It was a brand new one.**

***Worker:*** **And he sat on his lily pad and he went glug, glug, glug, which in frog language means—**

***Tim:*** **thank you and all the people at the hospital for helping me.**

***Worker:*** **And the people at the hospital said they never had a nicer frog than Fog who came from the bog.**

### *Discussion*

The extent to which I could help Tim depended upon our developing a relationship of trust. His naming of the "Two Men Club" indicated the possibility of his readiness to use a close male relationship. Because such a relationship was new to him, many sessions studded with long awkward silences were required to nurture it. During these sessions play proved to be invaluable as a way to establish rapport.

Considering his background and the intensity of his feelings, Tim's hesitancy to reveal himself was understandable. Even within the safety of an increasingly trusting relationship, Tim found it difficult to express his most troubled feelings—of impotence, helplessness, and fear. In his fantasy world of animals and the jungle he found a medium for expressing them symbolically. However, he feared too much to risk expressing these feelings directly to me, even in fantasy language. Here, the dictaphone played the pivotal role; it could not reject him. That the stories he told were really meant for me was unmistakable from Tim's own behavior in insisting that I play the records back and then covering his ears in fright. Only after the fantasy had been woven and spoken through the impersonal dictaphone and had been heard, understood, and not rebuffed by me could Tim begin to express his fears directly, as he did about the nightmare and the knife.

I chose an indirect approach in handling the material presented in Tim's stories. I allowed him to tell them without interruption. After carefully listening to the playback, I would make a quiet, general

comment about the central theme (fear, death, helplessness) without tying it to Tim or his situation. I always followed this comment with a direct reassurance to Tim that he was doing well and getting better, thus responding to the underlying feelings of doubt and uncertainty which he was expressing through the stories.

I chose this approach rather than direct interpretation for several reasons. The mere process of making and listening to the records and having me there seemed to decrease some of Tim's general anxiety. He was becoming more relaxed with me and his behavior on the unit and during sleep was less agitated. Also, I had the feeling as he watched me listening to the playback that he felt I understood what he was trying to say. In addition, the content of the stories seemed to progress in intensity and closeness to reality, indicating that Tim was moving on his own toward a more direct expression of his feelings.

Had Tim appeared more disturbed with me, at play or when asleep, I would have considered either stopping the recording or beginning some direct interpretation, using the story material as a bridge to discussion of his real anxieties. This course would have required consultation and guidance from the psychiatrist and would have required enough time on my part and enough energy on Tim's to deal with the uncovering of deep anxieties.

One of the difficult decisions associated with our relationship was my continuing to see Tim after he left the hospital. Ordinarily, discharged patients who need continued service are referred to an appropriate community agency. Tim's discharge, however, came rather abruptly and at the time of his most intense relationship with me. A break then would have meant a rejection of his hard-won ability to use help. More time was needed to prepare Tim for the termination of our contacts and for the gradual encouragement of his ability to develop other relationships with people in the community who could help him. While our final separation was difficult, it came only after Tim had integrated much of his experience with me, and after the integration had been tested and proved in his use of the community resources provided for him.

The foregoing points describe the conduct and rationale of the work, but they do not touch the heart of the treatment. This was the elemental process of responding to a weakened, struggling child's need for love, strength, and understanding. Tim's sobering words and fears deepened my respect for the impact of critical illness and surgery on children. His growth during the period of our relationship heightened my appreciation of the potential of direct, limited-focused casework treatment in helping sick children.

Tim's future is uncertain. His heart is too damaged to carry him very far and soon he will face another life-threatening operation. I am hopeful that he will be able to approach this experience with increased emotional strength and capacity.

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**And so we move into the age of space. What mental equipment shall we carry with us on this leap into the unknown? What shall be our credentials as citizens of the brave new world? Shall we go as Neanderthal men, weighted down with suspicions, fears, and hatreds of our Adamic ancestors, or shall we go as men and women, erect and unafraid, recognizing every other man and woman on this now tiny orb as full and equal partners in the most fundamental and enduring of all enterprises? That enterprise is to develop human capacities for good to the ultimate limit of their potential.**

***Whitney M. Young, Jr., Executive Director of the National Urban League, at a conference of the League.***

# SERVICE TO THE RETARDED AS SOCIAL WORK EDUCATION

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A PARADOX of service to the mentally retarded is that while this field has been long distinguished by the participation of many professional disciplines, the professional education of the practitioners has almost uniformly failed to include relevant content. Whether pediatrician, psychiatrist, educator, psychologist, public health nurse, or social worker—the professional has usually acquired his knowledge and skills in mental retardation essentially through postgraduate practice.

This state of affairs cannot continue if we are to meet the challenge of mental retardation in terms either of numbers or qualifications of the professionals required. Nor can we continue to demand that the institutions and agencies serving the mentally retarded bear the major responsibility of providing their practitioners with the special expertise needed for effective service. Obviously, each of the professional schools concerned must assess and modify its curriculum to meet this challenge.

The problem of how to include content specific to mental retardation in an already overcrowded curriculum is not unique to social work. But "curriculum space" is not the only problem the schools of social work face. If they are to fulfill their obligation to produce in this period of accelerated social change a professional person capable of effective service in the many and varied problem areas already defined—not to mention those yet to emerge—the schools must resist those forces encouraging fragmentation and restrictive specialization. As specialized content is considered for addition to the curriculum, it must be evaluated with reference to what it displaces. But, more importantly, it must be examined to determine its ultimate contribution to the common core of knowledge, skills, and values which constitute the essence of social work practice in any field. Learning experiences that best further this overall goal are most certain to be included and kept in the curriculum.

This article will examine the validity of social work field instruction in agencies serving the mentally retarded as sound preparation for social work practice in general. Its thesis is that student experience gained in study and service to the mentally retarded child and his family not only helps insure inclusion of content relevant to this crucial problem in the social work curriculum but also meets the highest standard of social work education by the enrichment and extension of the total educational experience.

It is often said that the field of mental retardation is too highly specialized to meet the learning needs of social work students. In view of the commitment to generic social work training permeating social work education today, this contention cannot be ignored. The issue of generic *versus* specific in social work education is a legitimate one that commands critical attention.

Obviously the generic-specific issue should not be an either-or controversy. There is no such thing as a generic agency, a generic client, or a generic service. Yet each instance of social work activity occurs in the context of professional social work practice and is a definite and concrete manifestation of its responsibilities, its perception and definition of problems, its

body of knowledge, its prescriptions of action and techniques for intervention, and its value perspective. The social work student must learn how to know, how to see, and how to respond as a social worker in situations where he is called upon to perform as a professional.

In a generalized sense every social agency worthy of the name offers the opportunity to contribute to this process of becoming a social worker. But for the purposes of social work education this is not enough. To determine whether the field of mental retardation is effective for the development of this identity and capacity, we need to inquire further into the range, visibility, complexity, and saliency of the learning experiences it provides.

### *As the Student Sees It*

Crucial to the attainment in social work practice is the process of selective discrimination. The student coming to the field of service to the mentally retarded finds it difficult to perceive where this experience fits in with his becoming a skilled social worker. The condition of the retarded person looks so hopeless and final that he doubts that this is a proper area for meaningful social work intervention. Differential social diagnosis and subtle and creative treatment goals seem irrelevant and futile.

Initially, the simple fact of mental retardation is the only reality for the student. He concludes that attendant manifestations—illegitimacy, delinqency, or poverty—are attributable in a simple and final sense to low mentality. He does not readily see that mentally retarded persons have a growth potential, that the differences among them are real and significant, that they share the hopes and fears of all mankind, and that they and their families can use and desperately need the services of the social worker in ways that make crucial differences. But with experience, under the guidance of an informed field instructor, the student develops a growing capacity to discriminate those facets of the situation responsive to social work intervention.

In this process of discrimination, the student from the outset must come to grips with his lay preconceptions. This is a demanding and sometimes painful process. But students who have had this experience report, long afterwards, that this capacity to discriminate, as well as the conviction of the validity of social work gained through this experience, has served them well. I do not suggest that this is due to the shock effect of service to the mentally retarded. Rather, it is the product of the nature, range, and saliency of the learning experiences that make such an invaluable contribution to the development of social work skill and perspective.

### *Application of Theoretical Concepts*

Mental retardation is a problem that cuts across class, ethnic, and religious lines. The social worker must be familiar with such factors and be able to assess and relate them to his social diagnosis and treatment goals. The problem strikes the individual, the family, and the community and demands solutions which resolve or mediate conflicting interests. It hits all age brackets. Thus, the social worker must know the needs and potentialities of each stage in man's life cycle.

The complexity of society and its highly institutional organization cannot be ignored by the social worker. Social work has reflected growing awareness of the importance of this perspective—an awareness documented in a heavier social science emphasis in the academic curriculum and a growing sophistication in discussions of social work issues and practice. Once the mark of distinction for the social worker was his ability to speak knowingly of the stages of psychosexual development, ego defenses, transference, and the like; today he must be equally conversant with such concepts as social role, socioeconomic class, power structure, social systems, and institutional networks. But for the practitioner, theory without the opportunity to apply and test its validity and relevance has limited significance. Therefore, increased attention is being directed to the student's field experience to provide vital and concrete meaning to these concepts. Here service to the mentally retarded offers a unique learning experience, particularly in understanding the individual's relation to society, its institutions, and the forces for social change.

For example, workers with the mentally retarded become quickly aware that the retarded person's self-image is determined inordinately by the way society views and values him. Because the focus on him is mostly negative he, and frequently his family, becomes the victim of social isolation with stressful consequences for all concerned. Furthermore, retarded persons have a special characteristic: Unlike others in our society, they experience excessive difficulty in having their needs met through the normal social institutions. Whether it be school, church, law, recreation, or work, each institution must adapt its program to the retarded person's special needs if he is to participate.

Today the professional literature is replete with the application of social role theory to problems in social work. If one wishes to bring to the student's attention the significance of social role as a factor in his diagnostic formulations, what better example is there than the parent of a retarded individual? The parent is called upon to fulfill the parental role throughout his lifespan with no regard for his changing capacity or needs—or for the conflicts and distortions this creates in his other roles and their demands on him in the successive phases of his life.

Few field experiences offer such a rich and varied potential for the student in the application of concepts and theories from the social sciences. In no other problem area does the individual's relation to his society and its institutions stand out in such sharp relief.

The family is an important part of the institutional framework as well as the primary unit of our society. In social work intervention, the family occupies a unique place. In mental retardation, the family is both the matrix for understanding the retarded person and, more often than not, the locus of the problem brought to the social worker's attention.

Family dynamics constitute a substantial segment of social work curriculum. Few settings equal those serving the mentally retarded in providing the student with opportunities to witness the strivings, vicissitudes, and dynamics of family life in all stages of development. The impact of the crisis and the chronicity of mental retardation involves all members of the immediate family, and its consequences may reverberate to the farthest reaches of the kinship structure.

There is little likelihood that workers schooled in service to the mentally retarded will lose their family-oriented perspective; intervention predicated on any other perspective would be an absurdity. Students trained in this area of service, regardless of their ultimate field of practice, are likely to reflect a family-focused orientation, both in assessing the determinants of behavior and in defining the problem to be solved.

The social work student is repeatedly taught that human behavior is biologically, psychologically, and socially determined. If this conception is not to remain an abstraction, he must test its validity and applicability in assessing his clients and their problems. This conception is inescapable in the field of mental retardation. It is not only essential to effective social work practice, but it also shapes the structure of the programs and the kind of professional personnel who serve the retarded. Working with other professions in a common effort, the social work student learns to appreciate the significance of the knowledge and expertise they bring to bear on situations in which he is immediately involved. He also learns to define his own professional role in interdisciplinary practice.

### *Basic Knowledge*

Since social work is always practiced in relation to a particular problem area, the student needs much specific knowledge and information about the given problem *per se*. In addition, he must have the kind of knowledge which is the base of his activity as a social worker wherever he may practice. It is essential that he distinguish between these two bodies of knowledge, however intertwined they may become in application.

We do not wish to graduate students with the false assumption that they are prepared to work with any social problem in any setting without attention to its unique manifestations and characteristics. The highly identifiable and specialized body of knowledge pertaining to mental retardation which the student must acquire for effective practice in this field helps dispel this illusion; at the same time, it provides him with an understanding of a prime professional obligation—the necessity for the acquisition of particular knowledge relevant to his given area of practice, whatever it may be.

There are many opportunities in the settings serving the mentally retarded for the development of the student's basic practice skills. However, such settings have particular significance to one aspect of current developments in social work practice and education: The boundaries that once distinguished the various methods of practice are becoming blurred. We seem on the verge of a single social work method which for any individual social worker will, in varying degrees, encompass the skills of casework, group work, and community organization, and demand more than a passing knowledge of research, administration, and social policy.

Increasingly, the field of mental retardation is being used as a setting for training in social group work. The literature of mental retardation contains many reports of social work practice combining the methods of casework and group work in a creative synthesis. For the student in placement in a program for the retarded, his dependency on research is real and evident. The demand for new services for retarded persons makes the student a participant in

vital community organization efforts, and in the administrative processes that translate policy into action. If the social work student working with the retarded does not become a whole professional person, it is not for want of opportunity.

All aspects of social work curriculum reflect concern with values, but in his field work the student has the opportunity to put the value commitments of his profession to the test. Here ethical dilemmas do not come prepackaged and labeled. The student must not only define the relevant issues but select the resolutions that are consistent with the values and philosophy of his profession. Only through such a process can his profession's values become his own.

I know of no setting superior to that of the agency serving the mentally retarded in the demands it makes of the social work student to declare where he stands. Perennial questions such as individual *versus* societal rights, the right of self-determination, the obligation of society to provide each of its members an opportunity to realize his maximum potential, the tyranny and cost of prejudice, and the individual's essential worth and dignity—all quickly move from the abstract to the concrete through manifestation in the lives of clients. In the field of mental retardation we do not have to stretch our imagination to find learning experiences involving questions of ethics and values; we cannot ignore them if we try.

### *The Role of Tragedy*

One aspect of professional maturation has taken on new meaning and depth to me after working with students in the field of mental retardation—the stance of a social worker when confronted with the tragedies of life. Social work grew up in an era of optimistic belief in inevitable and ever-accelerating progress. There was even talk of the time when the need for social work would disappear. Many of us cherished the belief that we could not only cure the individual's ills and make him independent of us, but through our social action we could cure the ills of society.

The events of recent years and our developing maturity have tempered our initial optimism and demanded of us a new appraisal and orientation. The search for meaning and direction in these troubled times is not the student's alone. One of the deepest and truest motives that brings students to social work is related to this search, and it is the responsibility of social work educators to engage fully with them in this quest.

As a field teacher in the problem area of mental retardation, I have found two experiences deeply moving to my students. The first is coming to a realization of the essential tragedy of life. I refer to tragedy in the classical sense—each man must confront his aloneness as well as his relatedness, he must know suffering as well as joy, and he must die as well as live. But tragedy is not the same as pessimism, for in this confrontation with reality lies a release and freedom, hope rather than despair. The ordeal through which the student achieves this wisdom is not an easy one. Indeed, there are many who never attain it. But if it is not realized in training through service to the mentally retarded and their families, it is not the fault of the placement. Here the student learns that all cases do not have a happy ending, all ills do not have a cure, and that often he must settle for the limited goal and find satisfaction in doing his best to minimize losses.

Hard as this lesson is to learn and accept, there is still another to be learned. I recall the young student who had the responsibility of telling a middle-aged woman that the only child she would ever bear was severely defective. He listened to her recite the hopes and dreams she had cherished for herself and the child, hopes and dreams that now could never be. He learned to stand with her in despair, share the burden of her grief, and still offer realistic hope; it was a tremendous accomplishment.

But an even more difficult and important lesson was that, although he could stand beside her, there would remain one sector of her suffering that he could not enter or do anything about. No matter how far along the way he went, in the end she must stand alone with her grief. That he could know this truth, that he could realize that this was his ultimate fate, too, gave a new dimension to the meaning of acceptance, a dimension that would forever be his.

To recognize and accept the tragic aspects of life is a liberating rather than a constricting viewpoint that admits realistic, not false, hope. The student who has been privileged to witness the themes of tragedy and hope in the lives of the retarded and their families will have come a long way in his quest to realize himself professionally as well as personally.

*An essay review . . .*

# AN UPSURGE OF INTEREST IN ADOPTION

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IT has been estimated that there are some 1.5 million adopted children in this country at the present time. In 1962 alone, courts in this country granted adoption petitions for about 121,000 children, 52 percent of them being adopted by persons not related to them.[1] Thus a substantial number of children and their families are directly affected by the institution of adoption.

Nevertheless, there have been very few attempts by social workers or other students of the family to develop any basic formulations about the adoptive family as one variant of this fundamental human institution in our society. Examination of the professional literature could easily lead to the conclusion that adoptive families are essentially the same as families whose children are theirs by birth.

The attempt to develop major theoretical perspectives about the adoptive family, seen from its unique characteristics, has had to wait until the appearance of the book, "Shared Fate," by H. David Kirk.* This is a provocative piece of work based upon a decade of research involving a number of projects which brought the author into contact with 2.000 families with adopted children. The theory spun out by the author will prove fascinating not only for readers interested in adoption but also for those who are enthusiastic supporters of theory-building in the behavioral sciences and social sciences.

Adoption has come to be viewed as a highly valuable resource of society. Much of the professional and lay literature about it tends to contain overt or tacit enthusiasm about what it has to offer deprived children and infertile couples. If there has been any intellectual soul-searching by professional persons concerned with this basic welfare service, it has been around such concerns as reducing the amount of time children spend in foster care before going into adoptive homes, finding adoptive parents for categories of children for whom this resource is not generally available—Negro children, physically handicapped children, older children—or focusing attention upon antiquated State legislation which has stood in the way of early abrogation of the rights of parents who are grossly neglecting their children.

All of this interest has had as its focus the task of providing needy children with good adoptive families. What happens to these children *after* they have been placed and *after* the courts have granted the adoption has only recently been the object of investigation.

Perhaps it is natural for professional social workers not to concern themselves with the aftermath of adoption since, with a few exceptions, their contact with adoptive families normally ends when the adoption becomes legal. Recently, however, some voices have been raised to suggest that it is time to stop thinking of the granting of the petition as the final scene of a drama in which all the major characters "live happily ever after."

For example, newly developed interest in the dynamics of adoptive family life was created a few years ago by the publication of an article by a psychiatrist in private practice, who found that there was a disproportionate number of adopted children coming to him for treatment of emotional disorders.[2] Similar findings were subsequently reported by staff persons at the Menninger Clinic,[3] and at the Child Guidance Center of Pittsburgh.[4] While these reports have overlooked the possibility that adoptive parents may be more prone than biological parents to use community treatment resources, and have used the wrong population base for their comparisons, their net impact has nevertheless been wholesome in that they have focused attention upon adoptive family life as an important area for family research.

Overall interest in the subject of adoption received another impetus with the recent publication of the findings of the followup study of independent adoptions in the State of Florida.[5] This study did not reveal major differences in the adjustment of adopted children when compared with schoolmates who were reared within their own biological families.

## *A Theory of Adoption*

Dr. Kirk's book represents an attempt to think creatively about adoptive family life and about the kinds of special problems which confront such families. He believes that adoptive

*Kirk, H. David: Shared Fate: A Theory of Adoption and Mental Health. Free Press of Glencoe, New York. 1964. 192 pp. $4.95.

parents in our society occupy a decidely anomalous position for which they—and those who must relate to them—are poorly prepared. He starts with the sensible assumption that a married couple does not typically anticipate being childless and that both husband and wife receive a rude shock when they find that they are not fecund. This view is also found in psychiatric literature which emphasizes the threat of infertility to the individual's self-image.

Dr. Kirk also points out that whereas couples who become parents through their own reproductive resources are able in the gestation period to prepare themselves, their relatives, and friends for their forthcoming parenthood, the adoptive couple is faced with abrupt change in taking a child and has no clear-cut outer signs or a timetable for gradually moving into the parental role.

Dr. Kirk sees adoptive parents as being hampered in their performance as parents by distorted attitudes held toward them by persons in the community at large. In one of his projects, for example, he asked adoptive parents to specify what their own parents' attitudes had been toward their first adoption. While at least 75 percent of the grandparents-to-be expressed approval, Dr. Kirk raises the question why there should be *any* holding back on the part of the older generation.

As a result of this and other studies he has conducted, Dr. Kirk believes that he has uncovered "covert" hostile or confused sentiments in the general population about adoption. Such a specter of unfriendliness will probably surprise most readers who are not themselves adoptive parents. Nevertheless, in this book he propounds the view that adoptive parents have to contend with considerable insensitivity from their contemporaries who have achieved parenthood through biological reproduction.

In building his case, Dr. Kirk makes use of data from a questionnaire mailed to adoptive parents in 1956; they were asked whether they had ever been the recipients of such remarks as: "How lucky you are that you didn't have to go through all the trouble of pregnancy and birth that I did," or, on introduction at a party, "These are those unselfish people with the adopted child," or, from a neighbor, "How well you care for your child, just like a real mother." Most people who responded reported that they had been on the receiving end of such insipid remarks either "occasionally" or "frequently."

In a further attempt to support his thesis of a nonbenevolent attitude toward adoptive parents, Dr. Kirk cites a meeting he arranged in which a group of adoptive parents discussed items on a tentative questionnaire relating to people's attitudes toward adoption. He found the members of the group very tense and reluctant to mention any untoward experience. He then told them about a remark which had been made to his own wife in relation to her care of their adopted child—"Why that's just like a real mother." This evidently opened a floodgate of feelings in the group members about the insensitivity of others to adoptive parents.

It would not seem difficult to dismiss Dr. Kirk's attempt to build a case for a finding of "role handicap" in adoptive parents based on strains stemming from the environment. The data he presents to support his theory are sketchy and some of the responses may have been conditioned by the somewhat dramatic activity of the researcher. The social desirability response-set, which Dr. Kirk's method of making use of his own status as an adoptive parent would tend to create, has been well documented in the psychological literature as one source of invalidity of responses to research questions.

However, despite the faultiness of his data, Dr. Kirk makes an eloquent case for the view that adoptive parents may *occasionally* encounter individuals who find it difficult to view the status of adoptive parents as being truly a *parent* role. Obviously, the man in the street has not been educated specifically on how to address himself to adoptive parents. In the absence of what Dr. Kirk calls a "cultural script," it may well be true that the general public is behaving in a way which may increase the distress of adoptive parents.

We do not know, however, whether adoptive parents react with uniform vulnerability to such assaults upon their sensibilities. This question warrants more rigorous research than has been conducted thus far.

### *The Role of Agencies*

Not only does Dr. Kirk see the general public's role in the lives of adoptive parents as less than positive, he also takes an ambivalent view of social agencies in this regard. He sees adoptive parents not only as being burdened with the oppressive knowledge of their infertility, but also as experiencing a distressing loss of autonomy in having to depend upon a "middleman" in order to acquire a child. And he notes: "This dependence tends to be increased in agency adoptions, which preclude direct transactions between natural and adoptive parents. In a more subtle sense, agency adoptions tend to make the adoptive applicants dependent because there is seldom an overt listing of the agency's criteria for the evaluation of applicants and their eligibility."

Dr. Kirk is also concerned about some of the social work profession's modes of operation, which he berates for its traditional emphasis upon testing for "hereditary potential of the child." However, his evidence for assuming certain orientations in the profession is also rather slim—mainly, memoranda made available from the Oklahoma State Department of Social Welfare in 1951 and from the Louisiana Department of Public Welfare in 1950.

He also shows a churlish concern about efforts to establish professional standards for child placement:

> . . . In the belief that only orderly procedures, governed by such standards, could assure to children a maximum chance of getting into good families, social work has long sought to limit child placing services to licensed agencies. This involved first of all an incessant stream of information and propaganda aimed at educating the public, potential adopters, and practitioners in other professional fields, such as medicine and law. A second step was to obtain legislation that would forbid any third party, not licensed as a child placing agency, to charge for child placing services. In the course of this campaign, carried out in the United States for over a quarter of a century, the official social work point of view was carried to the public by all the mass media of communication.

Through such unwarranted swipes at a group which, he avers, "seeks a monopoly of practice," Dr. Kirk lays himself open to criticism for failing to examine publications which are more current and more central to professional practice than the few pieces of literature he cites. He has obviously not examined the best guide to preferred adoption practice currently available, "Child Welfare League of America Standards for Adoption Service."[6] For example, he criticizes adoption agen-

cies for inducing adopters to think that its social workers can "match" the child "they might have had by birth." Thus he ignores the following statement in the Child Welfare League's guide:

**Similarities of background or characteristics should not be a major consideration in the selection of a family, except where integration of the child into the family and his identification with them may be facilitated by likeness, as in the case of some older children or some children with distinctive physical traits, such as skin color.**

**The ability of adoptive parents to accept the child as he is or may develop, regardless of how he may differ from them, is of greater importance than similar characteristics. It should be recognized, however, that people vary in their capacity to accept differences.**

### *Methods of Coping*

Having forcibly presented the view that adoptive parenthood contains special stresses and deprivations, the author identifies two methods for coping with these problems: (1) The *rejection-of-difference* approach in which the adoptive parent goes to great pains to deny that his situation is any different from that of the biological family; and (2) the *acknowledgement-of-difference* approach in which affirmation of differences is the coping mechanism.

For adoptive parents who would play down the uniqueness of adoption, the facts of the child's having been born out of wedlock and of their own infertility are regarded as essentially unpleasant phenomena which must be explained away. Such an orientation has implications for the ability of the parents to deal with the problem of revealing the adoptive status to the child. Such parents often create myths about the child's origins or they rely upon the defense mechanism of repression, forgetting much of the background information they secured about the child.

Dr. Kirk argues that the *acknowledgement-of-difference* approach is one that, in the long run, can be most effective in stabilizing the family and in developing the most wholesome environment for the child. However, he is critical of what he considers to be the failure of most adoption agencies to be sensitive to the dilemma implicit in the typical social work stress on recommending complete candor with the child about the adoption and about his birth status. Agencies, he says, too often err in insisting that adoptive parents tell the child he is adopted without at the same time helping them to anticipate the pangs of pain that are invariably aroused as these potentially disruptive elements are introduced into the family. He makes an eloquent appeal for more thoughtfulness and better theoretical grounding in this area.

### *Parents' Organizations*

One approach that Dr. Kirk obviously favors in helping adoptive parents meet their condition of "role handicap" through the mechanism of *acknowledgement-of-difference* is to create for themselves the lacking environmental support. He refers favorably to a phenomenon which, as yet, has taken hold only in a few cities: the formation of adoptive parents' organizations or "clubs."

Dr. Kirk is led to a positive view of this phenomenon through his conception of adoptive parents as facing role dilemmas similar to those faced by persons in minority groups. Stimulated by the work of Kurt Lewin, he sees a lesson for adoptive parents in Lewin's advice to Jews during the Nazi period: to learn to "accept their minority group position and make it a position of strength." Although he acknowledges that the problem of an oppressed minority is "in some respects quite unlike that of adoption," he is still intrigued with the many similarities of status between the two. He even sees one advantage that biological parents in a minority group have over adoptive parents: they share with the child the characteristics on which the social stigmas of minority group status are based. This interdependence is not ordinarily available to adoptive parents.

In Dr. Kirk's view, the adopted child, like the Jewish child under oppression, will have to face the fact that he is a member of a less privileged minority group. To do this he needs to build up a positive conception of himself, an ego-building process which is a critical parental task. The parent, Dr. Kirk believes, can best handle this responsibility in consort with other persons in similar straits. He sees parallels between this kind of affiliation, aimed at developing a sense of belongingness, and the affiliation of Negroes to the N.A.A.C.P. and Jews to the American Jewish Congress.

For this reviewer, such parallels seem grossly exaggerated. Membership in such clubs may, as the author believes, serve to reinforce the positive self-images of adoptive parents and give them greater assurance in the tasks they have to perform. However, such membership might also represent overdetermined reactions of a small segment of the population of adoptive parents to their own neurotic difficulties in being parents. Further, such clubs may help to create cultist organizations which can help divorce their members from the mainstream of normal living.

### *The Natural Parents*

Dr. Kirk brings fresh thinking to bear on the question of how adoptive parents handle information about the biological parents of their children. He makes a strong case for the values of open channels of communication between adoptive parents and child and of the ability in the former to present information about the child's natural mother sympathetically.

**. . . For the child to be able to comprehend at all how love could have motivated his first mother to give him up, he requires some additional information. Without it, he might come to fear that being loved in his present home he might again be given up. . . . The child therefore needs certain bare facts to understand his situation. Logically, the facts of birth out of wedlock and its attendant social and psychological problems should help to explain the necessity and desirability of adoption.**

For Dr. Kirk, adoptive parents can only be effective in helping the child cope with questions about his background if they can learn to empathize with these phantom-like biological parents. Here, he suggests the novel idea that agencies explore the possibility of a meeting between the natural parents and the adoptive parents before the child is placed. This is a daring suggestion requiring careful thinking through about unanticipated effects.

Dr. Kirk sees the key to success in adjusting to the role of adoptive parents as resting upon the couple's ability to resolve their own feelings about the sexual behavior of the natural mother of their child. He regards it as essential for adoptive parents to be convinced that:

**. . . their own more legitimate situation makes them not one whit more virtuous than the child's natural parents.**

. . . adoptive parents with absolutist sexual ethics will feel restrained from fully throwing in their lot with that of an adopted child who was born of unmarried parents. Indeed, such adopters are likely to see the adoption in part as an "uplift" or "salvage" operation, a circumstance which does not allow for a thorough interdependence of fate.

Dr. Kirk regards a successful adoptive experience as a "shared fate," one in which the lot of each actor is interdependent with the other.

On the book jacket the publishers maintain: "'Shared Fate' is a valuable source book of new information and thought on adoptive relationships." This is a valid statement even though serious reservations must be expressed about much of the data, which provide only a rather tenuous underpinning to the author's formulations. In the absence of *any* theory of adoptive family relationships, the fact that we now have available a carefully thought-through theoretical formulation is a welcome development. That it is out of contact with much of the thinking in today's adoption agencies need not diminish its value as a provocative stimulus to the creation of other theoretical formulations about adoptive family life.

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[1] U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: Facts about children: adoptions in the United States. 1963.

[2] Schechter, Marshall D.: Observations on adopted children. *A.M.A. Archives of General Psychiatry*, July 1960.

[3] Toussieng, Povl W.: Thoughts regarding the etiology of psychological difficulties in adopted children. *Child Welfare*, February 1962.

[4] Sweeney, Dolores M.; Gasbarro, Diana T.; Gluck, Martin R.: A descriptive study of adopted children seen in a child guidance center. *Child Welfare*, July 1963.

[5] Witmer, Helen L.; Herzog, Elizabeth et al.: Independent adoptions: a follow-up study. Russell Sage Foundation, New York. 1963.

[6] Committee on Standards for Adoption Service: Child Welfare League of America standards for adoption service, 1958. Child Welfare League of America, New York. 1959.

# Guides and Reports

STANDARDS AND RECOMMENDATIONS FOR HOSPITAL CARE OF NEWBORN INFANTS. American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Ill., 60204. Revised 1964. 89 pp. $1.50.

Among the new recommendations is that the term "premature infant" be replaced by "infant of low birth weight."

HALFWAY TO HEARTBREAK: OUR UNWED TEEN FATHERS. Joan Beck. Florence Crittenton Association of America, 608 South Dearborn Street, Chicago, Ill., 60605. 1964. 16 pp. 50 cents.

Suggests patterns of social service in helping the young unmarried father carry his share of responsibility for the future of his child and for his own future. Includes a section on older fathers of children born out of wedlock.

REVIEW OF LEGISLATION TO PROTECT THE BATTERED CHILD; a study of laws enacted in 1963. Vincent De Francis. Children's Division, The American Humane Association, P.O. Box 1266, Denver, Colo. 1964. 22 pp. 25 cents.

A comparison of the language, objectives, and philosophy of State legislation enacted in 13 States in 1963 for mandatory reporting of child abuse cases. The appendix includes the full legal text of legislation in 10 States.

NEUROMETABOLIC DISORDERS IN CHILDHOOD; proceedings of a symposium held at Sheffield, England, in May 1963. Edited by K. S. Holt and L. Milner. E. & S. Livingstone, Edinburgh and London. Available from The Williams & Wilkins Co., Baltimore, Md. 1964. 112 pp. $4.50.

Presents 12 papers on the biochemical aspects of a number of conditions, including phenylketonuria, galactosemia, and mongolism.

MENTAL RETARDATION: A FAMILY CRISIS—THE THERAPEUTIC ROLE OF THE PHYSICIAN. Committee on Mental Retardation, Group for the Advancement of Psychiatry, 104 East 25th Street, New York, 10010. Report No. 56, December 1963. 40 pp. 50 cents. Quantity rates available upon request.

Focuses on the physician's role in helping parents accept the diagnosis of retardation in their child and make realistic long-range plans for the child's care. Appendices include a simplified classification of mental retardation, a reading list for physicians and professional workers, and one for parents.

TOILET TRAINING AS A PREREQUISITE FOR ADMISSION TO A CEREBRAL PALSY PRE-SCHOOL. Virginia Thomas Reaume. Cerebral Palsy Association of Western New York, Inc., 309 North Street, Buffalo 1. 1964. 9 pp. 15 cents.

Describes the various types of help that the Cerebral Palsy Association of Western New York provides to children who are admitted to its preschool program in spite of the fact that they are not toilet trained.

OPPORTUNITIES IN SOCIAL WORK CAREERS. Joseph P. Anderson. Vocational Guidance Manuals, Universal Publishing and Distributing Corporation, 800 Second Avenue, New York, 10017. 1963. 128 pp. $1.45 paperback; $2.65 clothbound.

Describes the variety of opportunities offered in social work careers, discussing the development of social work as a profession and presenting information on social work education, organization patterns, and services performed by social workers in various types of agencies and organizations.

# BOOK NOTES

THE GROWTH AND DEVELOPMENT OF THE PREMATURELY BORN INFANT. Cecil M. Drillien, M.D. Foreword by Richard W. B. Ellis, M.D. The Williams & Wilkins Co., Baltimore, Md. 1964. 367 pp. $9.50.

On the basis of a series of studies conducted in Edinburgh, Scotland, since 1954, the author, lecturer in the Department of Child Life and Health at the University of Edinburgh, answers some questions and poses others about the growth and development of both prematurely born and full-term infants from birth through their early school years.

Attention is given to the usefulness, findings, and unresolved questions of previous studies done in this century. Two of the 10 chapters are devoted to the planning of a longitudinal survey, referring to current studies and outlining the procedures and methods of the Edinburgh survey. Other chapters are concerned successively with methods of classifying the families of the premature infants and the control groups, and with comparative data on physical development, health, and sickness in the first 5 years, and the varied patterns of maternal care, mental development, and behavior in the preschool and early school-age periods. The final chapter presents findings of a sample survey of 24 infants weighing 3 pounds or less at birth.

Graphs, tables, charts, and one photograph are included. Each chapter is followed by a list of references.

CHILDREN OF THE DEVELOPING COUNTRIES: a report by UNICEF. The United Nations Children's Fund. The World Publishing Company, Cleveland, Ohio. 1963. 130 pp. $3.95.

That "the adult can sometimes wait for things to improve, but the growing child cannot" is among the thought-provoking comments that accent this story about what the United Nations Children's Fund is doing for children in developing countries. Colored throughout by the concept that "we must prepare as well as protect the child," the book spotlights the prominent needs of these children—who number about half a billion—and the policy questions that meeting these needs generate. It outlines ongoing programs and the opportunities to do more, in health, nutrition, education, vocational training, and family and child welfare.

THE RESIDENTIAL TREATMENT CENTER: children, programs, and costs. Lydia F. Hylton. Child Welfare League of America, New York. 1964. 251 pp. $5.

The cost of care and treatment of emotionally disturbed children in residential centers is the focus of the study reported in this book. The report also covers the centers' operations, the populations served, and the administrative concerns of the workers directing the operations.

The study, conducted by the Child Welfare League of America with funds from the Field Foundation, reports on 21 public and private residential treatment centers located in various parts of the country and on 2 therapeutic day schools.

The more than 900 children cared for in the centers studied ranged in age from 5 to 21; the median age was 12.

Actual costs in these centers ranged from about $4,000 to $18,000 per child-year, including depreciation and the cost of maintaining empty beds—the wide variation being due to their many differences, especially in the ratio of professional staff to children under care. Only one out of six children referred for care in the period of study was accepted.

The study found that the fees charged in the residential treatment centers did not nearly cover the cost of care, although the median fee charged in such centers was estimated to be $3,600. The fee scales of most of the centers were reported as flexible, with private and public agencies contributing all or part of the discrepancy between fee and cost. Among the 17 centers in which cost analyses were made, only one had a top fee which surpassed its per-child-year cost; the rest had discrepancies ranging from $357 to $17,467, the median being $2,577.

The average length of stay of discharged children was slightly more than 2½ years.

WEDNESDAY'S CHILDREN: a study of child neglect and abuse. Leontine Young. McGraw-Hill, New York. 1964. 195 pp. $5.95.

This book reports on a study of 200 cases of severe child neglect and abuse. It describes parents who use extremely cruel methods to abuse, torture, even murder their children. According to the findings, many of these parents were themselves neglected or abused as children and never learned what love was. Some hate their children and tell them so. Generally, they are indifferent to the child's school attendance, personal hygiene, and clothing.

The author, professor of casework in the School of Social Administration at Ohio State University, sees a common thread running through these cases: Lower-than-average living standards, loosely knit family patterns, unemployment, limited education, substandard health care, isolation from the neighborhood, and acutely deviant personal behavior (alcoholism, prostitution, drug addiction). She suspects that these parents are most frequently found in crowded urban areas.

Such parents, Dr. Young reports, rarely seek help for their disorders or family problems. She points out that although they do come to the attention of a variety of community institutions—courts, schools, social agencies—only fragments of their problems are recognized, since each agency tends to perceive the mother and her children within the confines of its own specific function. The author therefore concludes that many cases of child abuse never reach a child welfare agency.

Maintaining that no service discipline knows how to treat such parents, Dr. Young makes a plea for the development of a community structure for early identification, reporting, and handling of abuse cases, and for the correction of the social ills which aggravate parental pathology.

# THE ECONOMIC OPPORTUNITY ACT OF 1964

On August 20, the President signed the Economic Opportunity Act of 1964. The Act authorizes appropriations totaling $947,500,000 for the fiscal year 1965, and such sums for the following 2 years as the Congress shall determine, to combat poverty in the United States.

***Title I,*** with a $412,500,000 authorization, provides for: (a) a Federal Job Corps to provide young men and women aged 16 through 21 with education, vocational training, useful work experience, and other appropriate activities in rural and urban residential centers; (b) federally aided State and community work-training programs for unemployed young men and women; (c) federally aided work-study programs to provide part-time employment for needy students in institutions of higher education.

The ***Job Corps*** is to be established within the Office of Economic Opportunity. The Office's director may enter into agreements with any Federal, State, or local agency or private organization for the establishment and operation of conservation camps and training centers in rural or urban areas and may provide or arrange for useful work, training, educational and other activities for the enrollees, including, but not limited to, conservation work. Enrollees may be provided with living, travel, and leave allowances, health services, and appropriate equipment and clothing and for a readjustment allowance on leaving of not more than $50 for each month of participation.

***Work-training programs*** for unemployed youth developed by State and local agencies and nonprofit organizations, on agreement with the Office of Economic Opportunity, may receive Federal aid up to 90 percent of the cost for the first 2 years of the Act's effectiveness and up to 50 percent thereafter. They must be designed: to increase the enrollee's employability or enable him to go to school; to contribute to a service in the public interest; to avoid displacement of employed workers; and to provide reasonable rates of pay; and must, insofar as feasible, be coordinated with public vocational training and education services. The work provided must be on public projects or on projects sponsored by private nonprofit organizations other than those connected with religious worship or instruction.

***Work-study programs*** offered by institutions of higher education for students who need employment in order to pursue their studies may be underwritten by the Federal Government up to 90 percent of the cost for the first 2 years of the Act's effectiveness and 75 percent thereafter. Ninety-five percent of the Federal grant must be used for payments to students for part-time work performed for the institution or for a public or nonprofit organization if the work is not on a facility used for "sectarian instruction or as a place for religious worship."

***Title II,*** with a $340 million authorization, provides for grants to public or nonprofit corporations or combinations of such for urban and rural community action programs; grants to the States for adult literacy programs; and the establishment within the Office of Economic Opportunity of an information and coordination center to encourage voluntary assistance to "deserving and needy children."

The ***community action programs,*** which may be federally supported in full or part, are to combat poverty through "developing employment opportunities, improving human performance, motivation, and productivity, or bettering the conditions under which people live, learn, and work." They must be conducted "with the maximum feasible participation" of the groups served.

In addition to the program grants the Director of Economic Opportunity may provide and make grants to the States for technical assistance to communities developing such programs, and may conduct or arrange for research, training, and demonstrations in connection with such programs.

***Title III,*** with an authorization of $35 million, provides for special programs in rural areas: loans to low-income families to improve property or farm operations and to finance supplementary nonagricultural enterprises; assistance in the establishment of programs for agricultural migrants; and indemnity payments to dairy farmers who suffered losses because of certain Federal actions.

The programs for agricultural migrants are specified as housing, sanitation, education, and the day care of children.

***Title IV*** provides for loans to small businesses.

***Title V,*** with an authorization of $150 million, provides for transferring funds to the Secretary of Health, Education, and Welfare to meet the costs of experimental work-training programs to "help unemployed fathers and other needy persons."

***Title VI,*** with an authorization of $10 million, establishes the Office of Economic Opportunity in the Executive Office of the President, with a director charged with implementing the Act, spells out its methods of staffing and operation, and provides for the establishment for a corps of volunteers to be known as the Volunteers in Service to America.

The volunteers are to be recruited, selected, and trained by the director and referred, upon request, to State, local, or private nonprofit organizations to perform duties in furtherance of programs combating poverty; and to work in programs serving Indians on reservations, migratory workers and their families, and residents of District of Columbia, Puerto Rico, and U.S. dependencies, and in facilities caring for the mentally ill or retarded.

***Title VII*** prohibits denying unemployment compensation to persons because of their participation in any of the programs provided for in Titles I and II; and provides for exemption of at least $85 of payments made to a person for such participation in determining his need for public assistance.

# HERE AND THERE

## *Health Grants*

In mid-July, the Children's Bureau announced the initial grants made under the increased appropriations and new programs authorized by the Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act. (See "Accent on Prevention Through Improved Service," by Arthur J. Lesser, M.D., CHILDREN, January–February 1964.)

### High Risk Maternity Cases

Seven grants were made under the new 5-year program to aid mothers and infants regarded medically as high risks. The recipients, which must shoulder at least 25 percent of the cost, were: The New York City Health Department; Richmond County Health Department in Georgia for that county and 10 surrounding counties; Puerto Rico Department of Health for the San Juan area; West Virginia Department of Health for the Morgantown area; Michigan Department of Health for Detroit; Baltimore City Health Department; and Illinois Department of Public Health for Chicago. Their projects will seek to increase the number of prenatal and post-partum clinics; pay for hospital inpatient care in voluntary hospitals; expand the medical, nursing, social work, and nutrition staffs of hospitals; expand public health nursing staffs; provide carfare to mothers of low-income families for travel to and from clinics; provide homemakers to teach these mothers good child care practices; and use trained nurse-midwives to provide direct service to patients. They will focus especially on building up services in areas with high rates of prematurity, infant mortality, and lack of prenatal care.

### Ongoing Health Programs

Under the increased authorization of $5 million each for the regular Federal-State maternal and child health and crippled children's programs, the Bureau made grants to 10 State health departments and crippled children's agencies to expand services for mentally retarded and multiply handicapped children and to 19 institutions of higher learning for special projects to focus on the training of personnel for these and related services.

The States' expansion of services will include enlarging and increasing diagnostic and treatment clinics; the initiation of clinical evaluations of children in institutions; the extension of screening programs for detection of mental retardation; and the establishment of treatment services for mentally retarded children who are also physically handicapped. The recipient States are: Idaho, Minnesota, New Mexico, Maryland, New York, Tennessee, Iowa, Texas, Georgia, and Pennsylvania.

The university projects will focus on training personnel for services for the mentally retarded and the multiply handicapped, training in nurse-midwifery, and the establishment of genetics laboratories for training personnel for genetics counseling services. Included, for example, were grants to:

- The Medical School of the State University of New York at Buffalo for a new genetics laboratory to provide facilities for detection, diagnosis, and study of inborn and other errors of metabolism and chromosomal abnormalities. Genetic counseling will be a consultative service to the pediatrics department.
- The Nebraska Psychiatric Institute, University of Nebraska, to develop personnel training resources and facilities for evaluation and counseling of multiply handicapped children and their families.
- The Baylor University College of Medicine for an evaluation and treatment clinic for mentally retarded infants and young children that will provide training opportunities for medical students, pediatric interns and residents, and students in psychology, social service, nursing, and education in relation to mental retardation.
- The University of California at Berkeley to set up a training program for medical personnel in the administration of programs for mentally retarded children and to strengthen the teaching program of the School of Public Health concerning mentally retarded children with multiple handicaps.

### Health Research

The Bureau's initial grants under the new maternal and child health and crippled children's services research program were focused on developing programmatic research (see "Child Welfare Research," page 200) in the maternal and child health departments of selected schools or university departments of public health. In addition to carrying on significant service-related research, these schools of public health are to act as regional research consultants to the local State, county, or city health officials in regard to studies of infant mortality, prenatal care, and crippled children's services. They are: Columbia Univresity; University of California, Berkeley; University of North Carolina; University of Puerto Rico; Harvard University; Tulane University; and the University of Michigan.

Research grant recipients included:

- The Department of Biostatistics, Harvard School of Public Health, for development of a series of national studies for the assessment of the health status of mothers and children and the availability and utilization of health facilities in a selected sample of high-risk communities.
- The Tri-County District Health Department, Aurora, Colo., for the construction and testing of a maternal health index.
- The Visiting Nurse Association of the Denver Area, Inc., Denver, Colo., for developing a method for evaluating the quality of nursing service to maternity patients.
- The Childrens Hospital of Los Angeles, Calif., for a study into ways of bridging gaps in doctor-patient communication.
- The American Speech and Hearing Association for a study of hearing aid evaluation procedures.
- The Columbia University School of Public Health and Administrative Medicine for a study of health and medical care of mothers and children in an urban community.
- The University of California Medi-

cal Center, San Francisco, for a study of children's lower-extremity orthopedic problems.

- The Emory University School of Medicine for an investigation of reproductive wastage in a high-risk urban indigent population.
- The Johns Hopkins University School of Hygiene and Public Health for development and evaluation of a self-administered health questionnaire for school children.
- The University of California at Los Angeles for a study of a legged walker for child amputees.
- The University of Michigan for a study of methods for evaluating the speech and behavior changes which accompany therapy programs for children with oral clefts.

**Planning Grants**

Under the authorization for community planning grants, provided for by the same amendments to the Social Security Act, the Public Health Service had by mid-July made grants of $30,000 each to 42 States and territories for planning comprehensive programs of prevention, treatment, and amelioration of mental retardation. The States must pay at least 25 percent of the total planning cost to be eligible for a planning grant.

## *Child Welfare Research*

In recognition of the acute shortage of competent research personnel knowledgeable in the areas of child welfare, mental retardation, and maternal and child health, the Children's Bureau during the past year has initiated a new phase in research strategy in its programs of child welfare research and demonstration grants and the newly approved maternal and child health and crippled children's services research grants. (See page 199.) This is the encouragement of programmatic research—a long-term commitment by the research agency to a specific aspect of the program field, entailing two or more intensive studies of related problems by personnel knowledgeable and career-directed in the problem areas. The purpose is to develop a basic continuing institutionalized framework for seeking knowledge that has meaning for the advancement of the programs and services with which the Bureau is concerned.

Thus in the field of child welfare, grants have been made for programmatic research in the area of child care to:

- The Child Welfare League of America to conduct a coordinated research program in foster care focused upon the problems and practices in all types of placement services for children.
- The Jewish Board of Guardians, a voluntary agency in New York, to concentrate on what can be done to increase family capacity for child care in order to avoid total separation of children from their parents.
- The School of Social Service Administration, University of Chicago, to look into the circumstances under which social work intervention culminates in parent-child separation.
- The Columbia University School of Social Work for studies regarding children not being well served by existing programs.
- The Center for Urban Studies, University of Chicago, for a series of national studies relating to the adequacy of the physical facilities used for the group care of children under social work auspices.

Other programmatic research grants have been made for research relating to legal authority, law, and legal processes as they affect child welfare services. They went to:

- The School of Law, Columbia University, for a study of child welfare agencies and legal authority; and for a study of State legislation concerning abused children.
- The School of Law, University of California, to study the impact of law upon the mental, physical, and moral health of the family unit.

Other grants for child welfare research were recently awarded to:

- Comeback, Inc., New York City, to study availability and use of recreation resources for chronically disabled children.
- The Massachusetts Fund for Children and Youth to investigate the use of community health and welfare services for children.
- The Washington Center for Metropolitan Studies, Washington, D.C., to study legal protections for children with mental disorders.
- The University of Chicago to investigate the evaluative designs of all child welfare demonstration programs.

Recently awarded grants for child welfare demonstrations have gone to:

- The Jewish Vocational Service of Chicago to demonstrate the integration of vocational services with existing treatment programs for emotionally disturbed adolescents.
- The Camp Fire Girls, Inc., to demonstrate the use of small voluntary groups to strengthen the physical, emotional, and cognitive development of mentally retarded and culturally deprived girls.
- The Rhode Island Department of Social Welfare to demonstrate the use of day-care services as an integral part of the program of aid to families with dependent children.

## *Against Delinquency*

Late in June, Congress extended for 2 more years the provisions of the Juvenile Delinquency and Youth Offenses Control Act of 1961. The Act authorizes a $10 million appropriation for the fiscal year 1965 but leaves authorization for fiscal 1966 for future congressional action. In addition, it authorizes $5 million for a special project to be carried out in the Washington, D.C., metropolitan area to demonstrate "the effectiveness of a large-scale well-rounded program for the prevention and control of juvenile delinquency and youth offenses." The program will include among other things guidance and counseling services to supplement those provided by the school system and the establishment and operation of halfway houses.

The Act also directs the Secretary of Health, Education, and Welfare to make a special study of compulsory school attendance laws and regulations in relation to their effects on juvenile delinquency and youth offenses. An interim report is to be transmitted to Congress on or before June 30, 1965, and a final report by January 31, 1966.

* * *

The Office of Juvenile Delinquency and Youth Development has recently awarded to the Houston Action for Youth, Inc., Houston, Tex., a grant for a demonstration project which will focus on the neighborhood organization, the development of services, and a youth employment program. Residents of disadvantaged neighborhoods will be helped to recognize problems, to identify what they themselves can do about them, and to know how they can make their needs known to the decision makers of the community and join with

them to bring about social changes. The neighborhood activity is to be an integral part of planning for modification and expansion of services, a process in which representatives of the service structure and the community at large will also be involved.

The youth employment program will experiment with new approaches and techniques in providing counseling and training for unemployed out-of-school youth between the ages of 16 and 22 and in recruiting and training its own staff members.

## *Child Welfare*

A new State law requiring the reporting of suspected child abuse went into effect in New York State on July 1 of this year. Passed in the 1964 general legislative session, the law requires physicians, dentists, or superintendents of hospitals or other institutions to report suspected cases immediately—either to an authorized child protective agency or to a public welfare official. The law provides immunity from civil or criminal liability for persons making such reports in good faith.

In response to the New York legislation, the New York City Department of Welfare has set up a central registry for the recording of abuse reports, located within a newly established child protective services unit in its Bureau of Child Welfare.

Louisiana has a similar law, also passed in 1964, but this requires that cases be reported to a law enforcement, rather than a welfare, agency.

. . .

The abuses, dangers, and possibilities of foster care in meeting the needs of children from broken or unstable families were the subjects of 3 days of discussion in Oakland, Calif., in mid-June by 26 child welfare specialists who met together under the sponsorship of the National Study Service, the California State Department of Social Welfare, the California Youth Authority, and the Alameda County (Calif.) welfare and probation departments. Purpose of the meeting was to discuss ideas for new approaches to meeting children's needs.

The discussion, which focused on 31 cases, proceeded from two basic assumptions: (1) the importance of using every service available to strengthen the ability of the child's own family to provide him with adequate care; (2) the importance of early recognition of situations in which this is not a realistic goal so that a permanent plan—preferably adoption—can be made for the child.

Among the many suggestions made for improving services were:

- Subsidizing adoptive families who could not otherwise afford to take a child in care—with a time limit on the financial aid.
- Assumption of guardianship by foster families for children in long-time foster care.
- Agency employment of foster parents with requirements that they attend agency training sessions.
- The encouragement of specialization among foster families.
- The establishment of group homes focused on the child's stage of development.

Adequate payment of foster families, improved casework services, low caseloads, and a wide range of supplementary community services were repeatedly stressed as essential to any child-care program.

The National Study Service is preparing a full report of the meeting which will be published in the near future through the cooperation of the California State Department of Social Welfare.

## *Unmarried Mothers*

A guide for collaboration of physician, social worker, and lawyer in helping the unmarried mother, developed by representatives of the three professions concerned, has recently been released for distribution by the four organizations which have formally approved it: The American College of

### THE CIVIL RIGHTS ACT OF 1964

The Civil Rights Act of 1964, signed by the President on July 2, contains 11 titles banning discrimination because of race, color, or national origin:

*Title I* bans discrimination in voting where Federal offices are involved, and prohibits registrars from using different standards for voters.

*Title II* bans discrimination in public accommodations: hotels, motels, and other lodgings except owner-occupied places with not more than five rooms for rent, and eating places, gas stations, and places of entertainment.

*Title III* bans discrimination in public facilities, including hospitals, libraries, parks, and swimming pools owned, operated, or managed by State or local governments.

*Title IV* authorizes the U.S. Commissioner of Education to extend technical aid to State and local officials involved in school desegregation and to provide training for teachers in problems produced by desegregation.

*Title V* extends the life of the Civil Rights Commission 4 years.

*Title VI* bans discrimination in programs aided by Federal grant, loan, or contract against any person because of race, color, or national origin.

[Regulations of the Department of Health, Education, and Welfare pursuant to this title are awaiting the President's signature.]

*Title VII* bans discrimination by many employers, labor unions, and employment agencies in hiring, firing, promoting, or referring workers because of race, religion, or sex. Effective 1965, this section will cover only employers and unions with 100 or more workers or members. The number covered drops by 25 each year, reaching a minimum of 25 in 1968.

*Title VIII* orders the Secretary of Commerce to compile statistics on voting in areas selected by the Civil Rights Commission.

*Title IX* allows the Attorney General to intervene in any civil rights case brought under the 14th Amendment if he certifies it is of general public importance.

*Title X* sets up a Community Relations Service in the Department of Commerce to work for voluntary compliance with the Act.

*Title XI* provides for a jury trial in all criminal contempt cases arising under Titles II through VII of the Act.

Obstetricians and Gynecologists, the American Academy of Pediatrics, the Child Welfare League of America, and the Children's Bureau. Pointing out that each of the three professions is responsible for advising the unmarried mother to consult with a member of the other two, the guide outlines the specific responsibilities of each discipline.

The physician is "held responsible for the physical and mental health of the patient" but is specifically advised not to become involved in any way with the placement of the infant.

The social worker is held responsible for the "distinctive social and emotional problems connected with having a child out of wedlock," including counseling the patient on plans for her own and her child's future.

The lawyer for the unmarried mother is held responsible for counseling her on the legal consequences of keeping or giving up her child and on her legal rights in respect to the child's father. He is advised against representing the prospective adoptive parents or becoming involved in any way with the placement of the infant.

All three disciplines are held responsible for recognizing the right of the unmarried mother to make decisions for herself and her child—"except where such rights are involuntarily terminated by court action"—and for individualizing each case in dealing with specific problems.

Copies of the complete text of the statement are available from the Children's Bureau without charge.

## *Sex Education*

Two workshops on the changing sex values of today's youth were held in New York this spring under the auspices of the National Social Welfare Assembly—one on March 31, the second on June 11—for the representatives of youth-serving agencies. Before beginning their deliberations in the first workshop the participants listened in on half-hour discussions of the subject by two groups of anonymous young people—one composed of five high school, business school, and college girls; the other, four college men, all freshmen. Each young people's group had an adult leader.

The young people told of their own and their friends' attitudes toward sex experiences, on the whole testifying that there is a great deal of heavy petting and sexual intercourse among boys and girls of high school and college age, which seem to have little or no relation to love. They spoke with satisfaction about the factual information they received in social hygiene and sex education courses but strongly expressed a need for opportunities to talk over with an adult the problem of sex in relation to their own behavior and the possible consequences of sexual experimentation. They reported that the barriers between themselves and their parents on this subject were too high to be scaled.

The workshop participants then considered the meaning of what the young people had said for the policies of their own agencies, especially in relation to providing guidance for young people, and the potential role in this of the youth leaders in their employ.

The second session of the workshop dealt with additional questions of policy and guidelines for sex education in informal settings. Program resources such as publications, films, and recordings were discussed.

## *Mental Retardation*

Thirty-nine cases of phenylketonuria (PKU) were found among the 400,000 newborn babies given a blood test between July 1962 and December 1963 in field trials of the Guthrie "inhibition assay," according to a report recently prepared by Robert Guthrie, M.D., and Stewart Whitney of Children's Hospital, Buffalo, N.Y. The field trials of the screening method developed by Dr. Guthrie were carried out by State health departments in 29 States in cooperation with the Children's Bureau. (See CHILDREN, September–October 1963, page 201.) The findings showed an incidence of approximately 1 in 10,000, as compared with an expected incidence of 1 in 20,000.

The report maintains that the field trials have demonstrated the practicality of the inhibition assay method for universal screening of newborns; and that early detection of all cases through such screening, coupled with the use of the available low phenylalanine diet, makes the eradication of mental retardation due to phenylketonuria an obtainable goal.

It also refers to current investigations at the Children's Hospital in Buffalo to determine the possibility of developing a "multiple test" for a number of other rare inborn errors of metabolism, using the same blood obtained for the PKU test.

Published by the Children's Bureau, the report, "Phenylketonuria Detection in the Newborn Infant as a Routine Hospital Procedure," is available from the U.S. Government Printing Office, Washington, D.C., 20402. (Price: 30 cents.)

. . .

The Children's Bureau is recommending that the States take steps to insure the routine testing of all newborn infants for phenylketonuria. Four States, Louisiana, Massachusetts, New York, and Rhode Island, have already enacted legislation making such testing mandatory. In addition, Illinois and Oregon have enacted permissive legislation. In California the legislature has directed that a committee prepare a report on the need for compulsory testing to be presented to the 1965 legislative session. Other States—for example, Minnesota—are launching statewide PKU testing programs by requirement of the State department of health.

. . .

With a grant of $2,200,000 from the Joseph P. Kennedy, Jr. Foundation, the University of Chicago is launching a multidisciplinary attack on mental retardation. Two-thirds of the grant will be used to establish a mental retardation research center, the remainder to establish a mental retardation clinic and training facility.

## *Smoking*

Twelve national health and education groups, with a membership of nearly 4 million people, organized the National Inter-Agency Council on Smoking and Health at a meeting held at the National Library of Medicine, Bethesda, Md., in early July. Directed toward youth, the council's purpose is to "develop and implement effective plans and programs aimed at combating smoking as a health hazard." Among the 12 are 3 Federal agencies: Office of Education, Public Health Service, and the Children's Bureau.

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**Photo Credit**

**Frontispiece, Esther Bubley for the Children's Bureau.**

# READERS' EXCHANGE

**REINHERZ:** ***A Connecticut program***

In her article on "The Therapeutic Use of Student Volunteers" (CHILDREN, July–August 1964), Helen Reinherz describes the effects of the experience of companionship on mentally ill patients. Since 1957 a companion program has been in operation at Connecticut Valley Hospital in Middletown, Conn. Under the direction of Dr. Jules Holzberg, director of psychological laboratories at the hospital, the program has expanded until it now includes over 150 students from 7 local colleges.

In contrast to the Harvard program, the focus of the research aspect of the Connecticut program has been directed toward the effects on the students rather than on the patients. The studies have demonstrated the following positive changes: a more realistic knowledge and understanding of mental illness; more positive attitudes toward the mentally ill; greater introspectiveness and self-acceptance; and greater tolerance for other people's sexual and aggressive behaviors. Future studies will be directed toward determining the persistence of these changes, to examination of the personalities of students who volunteer for the program, and the effects of using various combinations of students and patients.

In regard to the last point, 17 students were assigned to the children's service for the 1963–64 year. While the basic procedure was similar to the Harvard program, several exploratory modifications were initiated. In selecting patients, the primary criteria were the youngster's need for, and ability to profit from, such an experience and the facts that they were not considered "short-term" cases and were not receiving a variety of other social experiences. The boys and girls, 7 to 16 years, had diagnoses of schizophrenia, character disorder, or organic impairment.

The assignment of students to patients, with a few exceptions, was made by the individuals themselves: All were present at two social gatherings, and with some help were able to pair off satisfactorily. Aside from a general orientation, the students were not given information about the youngsters' backgrounds and problems until halfway through the year. This permitted the students to perceive the patients as children rather than mental patients.

As this was in general an exploratory procedure, definitive conclusions cannot be drawn. However, on the basis of interviews with all interested parties, the companion program was judged to be beneficial to the patients, to the students, and to the hospital functioning.

*Roy Korwin*
*Chief Psychologist, Children's Service, Connecticut Valley Hospital, Middletown, Conn.*

**BEALER et al.:** ***Authors' rejoinder***

Irene M. Josselyn in "Some Reflections on Adolescent Rebellion" (CHILDREN, May–June 1964) rejected the idea that a rebellious youth subculture is a myth, as we contended in the March–April 1964 issue of CHILDREN ("The Rebellious Youth Subculture—A Myth," by Robert C. Bealer, Fern K. Willits, and Peter R. Maida).

Through the example of the American Colonies' revolution against England, she notes that rebellion normally takes place within a system of shared values and focuses on the legitimacy of authority patterns. We have no quarrel with this meaning of rebellion. In fact, Dr. Josselyn's analogy very nicely points to one of the major contentions of our article. Put simply, the "great gesture" that the youth often makes of his rebellion should not be taken to mean total rejection of his parents. Just as the Colonies following their "rebellion" remained very "British" in culture, so adolescents who break with parental authority usually do not reject the basic ideals of their family.

However, there is a large body of writing which takes adolescent rebellion to mean a conflict over values and not one limited to authority patterns within values. Dr. Josselyn is not exempted here. Having argued persuasively that rebellion *can* occur without total rejection of parental values, she goes on to reverse herself by contending that adolescents "revolt against parental standards," and that while the "adolescent will verbalize standards that are derivative of parental standards . . . his behavior will be quite to the contrary."

We do not deny that conflict over authority occurs. Whether it necessarily signals rejection of basic parental values and whether it happens within most American parent-child relationships, as Dr. Josselyn contends, are other matters. The conclusion of our article, based on a large quantity of research evidence, was that authority conflict can occur independently of value conflict and that a high degree of value similarity between generations is the mode. Dr. Josselyn gave no data to challenge that conclusion.

In regard to the question of how widespread conflict over authority is, we simply do not know. Undoubtedly, Dr. Josselyn feels that this type of rebellion is extremely widespread. It is our impression that authority conflict is not so prevalent. However, neither her position nor ours had been adequately documented by empirical research.

Much of Dr. Josselyn's uneasiness with the points we made seems to center on a reluctance to accept certain facts which are contrary to her own ideals of what is desirable in terms of personality development. For example, she writes with considerable dismay:

**If adolescents are already so fixed in their attitudes, we should abandon our courses in philosophy or any others that we feel influence a resolution of the adolescent's confusion, a confusion based upon his need to find his own identity as an individual rather than remaining simply a reflection of his parents.**

Without examining the questionable assumption that confusion is vital to adolescent growth, it seems fair to point out two things: (1) To suggest that adolescents are not overwhelmingly rebellious is not necessarily to condone that acquiescence; (2) To conclude that it is necessary to give up efforts at change is simply not warranted. If change is to be brought about the starting point *must* be an accurate picture of reality. To point out the tendency for continuity in values and the subsequent difficulties of eliciting change does not mean alterations are impossible. It does emphasize the fact that the task is not simple.

Dr. Josselyn also was disturbed that we did not "consider the average adolescent . . . a member of a subculture because he has many values in common with adults," but with the same condition of partly shared and partly different values, allowed social class as a subculture. There is a simple misunderstanding here. In certain ways and on many occasions adolescents do constitute a subculture. What we did question is the image of a youth subculture rejecting parental values as "the characteristic or most widespread pattern of adolescent behavior."

Furthermore, through an example suggesting the relationship of the continuity of culture to the high school dropout problem, we showed that relying heavily on a youth subculture concept may not be the most insightful choice for fruitful analysis.

*Robert C. Bealer*
*Fern K. Willits*
*Peter R. Maida*
*Department of Rural Sociology, Pennsylvania State University*

HUNT: *What kind of poverty?*

J. McVicker Hunt's survey of our advancing knowledge of the intellectual development of children and his (as always) skillful relating of experimental findings to pragmatic considerations are much appreciated by this practitioner in the child welfare field. ("How Children Develop Intellectually," CHILDREN, May–June 1964.)

Because Dr. Hunt does such a fine job of substantiating impressions with facts, I was surprised to see some rather sweeping generalizations about poverty and its implications for the intellectual development of children. Specifically, poverty is said to feature crowding, adults ill-tempered because of discomforts and frustrations, and children's questions inadequately answered and sometimes provoking punishment.

This leads me to wonder just how much we do know about the features of poverty, and to ask how carefully have we defined the terms and concepts we use to describe this social (cultural, economic) phenomenon. There seems to be a tendency to use interchangeably (at least in the context of this article) the terms *low socioeconomic class*, *poverty*, and *cultural deprivation*. Of these, the first concept is the best understood and most consensually validated; the second is in the process of achieving acceptable definition; and the third is still subject to debate as to just what is meant. My own reaction is that the three terms are not necessarily correlated: There can conceivably be "lower class millionaires," cultural deprivation is found in all classes, there *is* an impoverished middle class and a culturally advantaged lower class.

We all "know" what is meant by these terms when used in this context, but is not our model usually the particular kind of poverty each of us knows best, most often the urban slum (where crowding *is* a problem)? What about the rural slums of Appalachia, small town poverty, agricultural and open country poverty, poverty brought on by technological unemployment or the physical disability of middle age?

In sum, there would seem to be a need for a great deal more clarification of these concepts, and particularly when they have such immediacy to many ongoing and proposed programs in nursery and grade schools, adoptions, vocational training, and foster care.

*Henry Kite*
*Social Worker, Vermont Children's Aid Society, Springfield, Vt.*

*Author's reply*

Henry Kite's call for a more careful and differentiated specification of the relationships among poverty, low socioeconomic class, and cultural deprivation is valid.

Although I suspect that crowding (with its attendant variety of input for infants during their first months after birth) and the ill temper of adults (arising from their discomforts and frustrations and resulting in a dampened parental responsiveness to infant locomotion and verbalization) are nearly universal concomitants of severe poverty, this is not the whole story.

When I say crowding and ill-tempered adults are well-nigh universal concomitants of poverty, I must confess that my empirical knowledge of poverty is limited. I have seen these concomitants in the rural shacks of the hand workers in the sugar beet industry, where I grew up. I have glimpsed them in the rural slums of Navajo country. I have seen them in the urban slums of New York City and Providence, R.I. Moreover, I suspect that Oscar Lewis is correct in his belief that he is describing a universal condition of poverty in his "The Children of Sanchez," which paints conditions not too diverse from those in which children whose parents are facing dire poverty in this country are growing up. But this impression of poverty is only a hypothesis for proper investigation.

On the other hand, Henry Kite is correct in saying that ill-tempered parents exist within the middle and upper classes. Although I suspect that they are less common than they are within the poverty-stricken of the lower and especially the lower, lower class, their existence makes it entirely feasible to find a substantial range of parent-child relationships within the middle and upper classes which might well be investigated for their effects on the developing intellects and personalities of their children.

Other factors are also involved in development. Dr. Norman Frederiksen of the Educational Testing Service, who has recently visited the bush-reared natives of Kenya, Africa—a people generally very responsive to their children—reports that these people do not recognize very familiar objects in pictures, either as children or as adults, unless they have had considerable contact with Western civilization. This implies that factors within the informational interaction of persons with their environment must be especially important in cognitive development. These factors are still not clearly specifiable, but they probably reside in encounters with two-dimensional representations and linguistic signs of objects.

Within our society, such factors in informational interaction are more typically available in the middle and upper classes than the lower. Such factors could readily be supplied by nursery schools and day-care centers.

As of now, I have no knowledge that permits more definite specification. Only if we attempt to develop programs with the purpose of fostering the intellectual and personal development of those children from slum backgrounds who, without them, are handicapped even on entering kindergarten can we expect to specify more definitely and clearly the relationships among poverty, low socioeconomic class, and cultural deprivation, and the factors most important for fostering the achievement of intellectual potential.

*J. McVicker Hunt*
*Professor of Psychology, University of Illinois*


U.S. GOVERNMENT PRINTING OFFICE: 1964

## SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

**Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.**

INSTITUTIONALIZING MENTALLY RETARDED CHILDREN: attitudes of some physicians. Simon Olshansky et al. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1963. 22 pp. Single copies available from the Bureau without charge.

The four reprints from professional journals included in this publication report on interviews in the Greater Boston area with 18 obstetricians, 30 pediatricians, 57 general practitioners, 20 hospital interns, and 20 first-year resident physicians. The large majority of physicians in each group favored keeping the preschool retarded child at home; almost all opposed separation of mother and retarded child at time of birth; very few considered the parents as the decision makers in determining institutionalization.

A NEW APPROACH—RELIEF ROLLS TO PAYROLLS; a community work and training program under the Public Welfare Amendments of 1962. Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services. PA1–8. 1964. 7 pp. Single copies free of charge from the Bureau of Family Services.

Describes typical work and training programs for public assistance recipients that State public welfare departments can provide with Federal financial participation.

FEES FOR DAY CARE SERVICES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1963. 20 pp. 15 cents.

This pamphlet suggests some principles and methods to be considered by agencies in establishing a flexible fee policy for day-care services.

THE MENTALLY RETARDED CHILD; a guide to services of social agencies. Michael J. Begab. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 404. 1963. 134 pp. 45 cents.

Written as a guide for social work personnel in training and in practice, this publication focuses on the impact of retardation on the family and the social problems which inhibit the maximum development of the retarded child and threaten the stability of his family. It points to the variables to be considered in planning effective services for mentally retarded children and their families.

CLINICAL PROGRAMS FOR MENTALLY RETARDED CHILDREN; a listing. Rudolf P. Hormuth. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1963. 36 pp. Single copies available from the Bureau without charge.

Listing by States 110 special clinical facilities for mentally retarded children, this publication is the fifth such compilation made by the Children's Bureau.

A GUIDE FOR PUBLIC HEALTH NURSES WORKING WITH MENTALLY RETARDED CHILDREN. Marian M. Holtgrewe. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1964. 49 pp. 25 cents.

Designed for public health nurses, this guide explains how the nurse can be an important liaison between the community she serves and its available resources in caring for the mentally retarded—and how she can provide help to the mother in management of the child in the home.

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